STATE TITLE V BLOCK GRANT NARRATIVE
STATE: LA
APPLICATION YEAR: 2005

I. GENERAL REQUIREMENTS

A. LETTER OF TRANSMITTAL

The Letter of Transmittal is to be provided as an attachment to this section.

B. FACE SHEET

A hard copy of the Face Sheet (from Form SF424) is to be sent directly to the Maternal and Child Health Bureau.

C. ASSURANCES AND CERTIFICATIONS

Assurances and Certifications will be maintained on file in the MCH program's central office. Requests for copies of these documents may be obtained by sending a written request by fax to (504)568-8162 or by mail to the following address:

MCH Block Grant Coordinator
Office of Public Health
Maternal and Child Health Section
325 Loyola Avenue, Room 612
New Orleans, LA 70112

D. TABLE OF CONTENTS

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published June, 2003; expires May 31, 2006.

E. PUBLIC INPUT

/2005/Input from MCH stakeholders was facilitated by publishing the MCH priority needs and activities in the May 2004 issue of MCH Coalition News. The 220 members of the MCH Coalition represent public and private hospitals, and obstetric and pediatric providers. This same information was distributed and orally presented to the Board of the Louisiana Coalition for Maternal and Child Health on May 24, 2004 for input. Recommendations included increased involvement with the private medical community by developing programs that promote breastfeeding with all birthing hospitals and to work closely with physicians to address dental health, smoking cessation and proper weight gain for pregnant women and SIDS and lead poisoning prevention for children.

The Title V Block Grant application has become more accessible to Louisiana's citizens via Internet access. A summarized version of the application was posted to the MCH website on 5/29/04 (see attachment or www.oph.dhh.state.la.us/maternalchild/index.html). The summary document was reviewed by 12 CSHS Parent Liaisons, 9 CSHS Community Outreach Specialists, and 6 CSHS Families from all 9 regions of the state. These parents provided positive feedback regarding the format, style, readability and listing of priority needs. Recommendations included engineering the feedback form so that it could be forwarded to MCH from the web site. Parents suggested that we address teen pregnancy rates in rural areas, improve the publicity regarding services offered, and that the Child Care Health Consultant Initiative increase efforts to educate childcare facilities in caring for CSHCN.//2005//

II. NEEDS ASSESSMENT

In application year 2005, the Needs Assessment may be provided as an attachment to this section.

III. STATE OVERVIEW

A. OVERVIEW

/2005/Louisiana is unique because of its history of a comprehensive publicly financed health care system to serve its large proportion of poor citizens. Up until recently, Louisiana has relied heavily on its regional, State-supported hospital system and large network of Maternal and Child Health (MCH) Block Grant and other federal and state funded public health clinics to directly provide preventive and primary health care for pregnant women, infants, children, and adolescents, as well as services for children with special health care needs, for its large medically indigent population. Maps 1, 2, and 3 of the attachment show existing Parish Health Units, State Charity Hospitals, and Federally Qualified Health Centers (FQHC's) respectively. Additionally, the MCH Adolescent School Health Initiative began in the early 1990's and provides funding for primary and preventive physical and mental health services in 51 state-funded and 1 federally-funded school-based health centers across the state.

Changes in the financing of health care services through the State system and the infrastructure of health department services have occurred in the past few years, which have affected the role of Title V in the health care system within the state. Since the Omnibus Reconciliation Act of 1990, Medicaid reimbursement for obstetric and pediatric care has increased, resulting in a growing participation of private physicians and hospitals in providing health care to Louisiana's low-income poor women and children. More recently, the State Medicaid Program has enacted several changes that have had a positive impact on financing health services for the low-income population. These include expansion of income eligibility for Medicaid through the State Child Health Insurance Program (LACHIP), expanded income eligibility for pregnant women, and statewide implementation of a primary care case management program for Medicaid recipients. This has resulted in decrease in the need for direct services through the public health units. Simultaneously, over the past several years, the state has experienced budget shortages that have impacted the services through the Department of Health and Hospitals. Beginning in January 1999, a hiring and spending freeze for all government agencies was instituted. The Department of Health and Hospitals Secretary extended this freeze indefinitely which included restrictions on purchases, contracting, out of state travel, and hiring. Programs were required to cut 10% from contract expenditures, and DHH staff was reduced to 1,800 employees during 1999. In December 2000, the Office of Public Health (OPH) implemented a lay-off of approximately 10% of the entire agency workforce. In the months preceding the lay-off, an additional 10% of OPH employees resigned. In November 2000, OPH discontinued the staffing of 25 parish health units. The staffing of 18 of these units was taken over by contract agencies including primary care centers or hospitals. Regional CSHS staff in the regions in which there was a separate CSHS clinic were integrated into one of the health units within the region. This major reduction in staff has affected the MCH and CSHS Programs in several ways, one being a decrease in the number of MCH and CSHS visits. A comparison of visits in 2002 compared to 2001 shows an 11% reduction in child health visits and a 12.8% reduction in maternal health visits. However, the number of pregnant women and children receiving WIC and women receiving pregnancy testing services in parish health units increased from 127,000 to 129,031. The number of children served by CSHS decreased from 5,792 in 2002 to 5,711 in 2003. However, the number of clinic visits has remained stable, indicating that children with multiple special needs and more severe medical conditions are enrolled in the program. Enrollment in CSHS is also affected by eligibility criteria that have not changed in over 15 years. In addition, the Title V CSHCN program was asked to take on the administration of the Part C program under the IDEA. This early intervention program has increased the staff and capacity of Title V in Louisiana to affect early development of children with disabilities and developmental delays.

Recent national events have impacted public health in the area of emergency preparedness for natural and man-made disasters with a primary focus on bio-terrorism. State and National sources of funding have been used to build public health infrastructure. Approximately 50 new positions in the Office of Public Health have been added. The presence of these new staff in

the areas of epidemiology, bio-terrorism coordinators, laboratory, and hospital nurse coordinators will have an overall impact of strengthening public health services. An example of how these efforts will complement Title V efforts is the use of a planned drill to test our capacity for mass immunizations as a focused community based effort to provide childhood immunizations which will impact our immunization rates.

Even with the improved financing of health services and changes in the public health delivery system, the need for MCH services continues. There remain areas where the Title V services continue to be a primary resource for prenatal care, preventive pediatric, and subspecialty pediatric services. Title V funds provide the wrap-around services for women and children receiving benefits from the Supplemental Food Program for Women, Infants, and Children (WIC) through 70 parish health units. These services include immunizations, prenatal and parenting education, case management, and referral for other health and social services. Although the numbers of women and children served through these clinics have decreased, services were provided to over 129,000 women and children, comprising a large percentage of the state's population of pregnant women and low income children under 5. Additionally, the MCH Program has continued to monitor the health status of Louisiana's mothers and children and has developed programs targeting those areas of the State with the greatest MCH needs. The savings in MCH funding resulting from the lay-off has been used to contract for the delivery of services by primary care centers, hospitals, medical schools and other community based organizations in those areas. Thus, the Title V Agency continues to play the role of assuring access to needed services for the State MCH population.

2. Health Care Needs of the State's Population

Louisiana has ranked poorly on national comparisons related to health status and care. A 2004 national report published by Morgan Quitno Press titled "Health Care State Rankings 2004" ranked Louisiana 48th, third to worst in the nation in health indicators. The report is based on 21 factors that reflect access to health care providers, affordability of health care, and the generally health of the population. Examples of factors include births to teenage mothers, percent of population not covered by health insurance, death rate, and the sexually transmitted disease rate. Louisiana's ranking as one of the most unhealthy states stems from its high rate of uninsured, low rate of physical activity, high rate of diabetes, high infant mortality rate, high cancer death rate, and high rate of low birth weight babies. According to the 2004 National Kids Count Report, Louisiana ranks 49th of all states on indicators of child well-being. Although improvements occurred in 5 of 10 of the indicators, Louisiana ranked 49th for percent of low-birth weight babies and for percent of families headed by a single parent and 48th for infant mortality rate, percent of children in poverty, and percent of children living where no-parent has full-time, year-around employment.

a. Welfare Reform
Changes in Louisiana's cash assistance program have had an impact on the status of Louisiana's mothers and children over the past few years. The original Aid to Families with Dependent Children (AFDC) which is now know as Families in Temporary Assistance Program (FITAP) is operated by the State Department of Social Services (DSS), a separate agency from the Department of Health and Hospitals, which houses both the Office of Public Health and the State Medicaid Program. Since July 1998, there has been a 77% decrease in the number of monthly cash assistance recipients to 28,955 by March 2004. In that month, of the 28,955 FITAP recipients in the state, 22,045 were children and 6,750 were adults. Thus far during State Fiscal Year 2003-2004, an average of 17,010 grants were paid each month with the average grant being $200.

As in other states, Welfare Reform brought about many changes to Louisiana's cash assistance program which have included limiting welfare benefits to two years in any five years; capping benefits at five years in a lifetime; and requiring twenty hours per week of work or work training, unless exempt. The impact of these changes on families is seen in the results

of a study on the effects of welfare reform in Louisiana that was performed by Southern University at New Orleans School of Social Work and funded by the Louisiana Department of Social Services. The Welfare Reform Research Project interviewed 370 recipients and found that 35.1% of the respondents remained dependent on FITAP as their main source of income. Of those who left FITAP, 37% left welfare voluntarily for reasons of improvement in their situation (i.e., finding a job or other source of income), and 63% involuntarily left, including those who reached the two year time limit on benefit receipt. The study documented the effect of barriers to employment such as unmet child care needs (after school care, before school care, summer child care, evening/night child care, child care for weekend shifts, and care for children under three years of age), low educational level, health/mental health problems, domestic violence, and access to transportation. Of particular importance were: 1) In the area of Domestic Violence, 10% of respondents were currently being physically assaulted or stalked, but only 28% of respondents had been screened by a welfare case worker for domestic violence. 2) The score on a scale measuring depression indicated the presence of depression in 69.5% of the sample. This study illustrates the continuing needs for not just health but also mental health and socioeconomic support services for women and their children in the State.

b. Louisiana population
According to the 2000 Census estimate, the total population of Louisiana was 4,468,976, indicating a 5.9% increase from the 1990 estimate. In terms of racial groups, 63.9% were white, 32.5% were black (more than twice the national figure of 12.3%), 1.9% were Other, and 1.1% were two or more races. A comparison of Louisiana and National race distribution is provided in Figure 1 of the attachment. The total number of women of childbearing age (15-44 years) for 2000 is 1,006,947 which is an increase from 1,002,566 in 1998. In 2000, teenagers 15-19 numbered 365,945 and included 184,378 male teenagers and 181,567 female teenagers. Male and females aged 0-14 totaled 1,002,084, making up approximately 22% of Louisiana's 2000 population. A table of 2003 parish population estimates is provided in Table 1 of the attachment.

Louisiana is a predominantly rural state. Only 13 of the 64 parishes have over 70% of their population considered urban. Seven of those parishes are located in the greater New Orleans metropolitan area. Most of the parishes in the Central and Northern parts of the State are rural.

According to the 2000 census, the per capita money income in 1999 was $16,912, or 78% of the national average of $21,587. The Louisiana Department of Labor reports that in April 2004, the overall unemployment rate was 5.9% for the State compared with a national rate of 5.6%. The 2000 census data shows that Louisiana with an overall poverty rate of 19.6% continues to have one of the highest poverty rates in the United States. The Census Bureau reports that Louisiana has the second highest 3-year average poverty rate from 1999-2001 with a rate of 17.5% compared with a national average of 11.6% (US Census Bureau, Poverty in the United States: 2001, September, 2002). Of the 64 Louisiana parishes, 19 have poverty rates greater than 25% with 3 with rates greater than 35%. Fifteen of these parishes are in the northern and central parts of the State. The 2002 National Kids Count Data Book reports Louisiana as having the 48th highest child poverty rate among the 50 states. Twenty-four percent of the children in Louisiana lived in poverty in 2001 as compared to 16% nationally. According to census data, 22.1% of families with related children under 18 years live in poverty as do 26.7% of families with related children under 5 years. According to the Census 2000, the Louisiana poverty rate for children aged 5 to 15 with disabilities was 35.3%, compared to 25.0% for those without disabilities. In the US, 25.4% of children with disabilities aged 5 to 15 lived in households with income in 1999 below the poverty level, compared to 15.7% of children without disabilities.

Low education levels are also a problem in Louisiana. Data from the last NALS (National Adult Literacy Survey) conducted in 1992, indicated that 28% of Louisiana adults performed at the lowest level of the five literacy levels. Data from the 2000 census indicates that 32% of the State's population over age 25 years had only a 12th grade education with 9.3% having less

than a 9th grade education.

c. MCH Health Status Indicators
Although Louisiana live births had shown little change in the number of reported live births over the past several years, in 2002 there were 64,755 live births which is a decrease of 438 births or 0.7% from 2001 (See Figures 2 and 3 of the attachment for Live Birth trends, including a breakdown by age and race of the mother). While the infant mortality rate in Louisiana had had an overall downward trend, the infant mortality rate in 2002 showed a 4% increase with the rate increasing from 9.8 to 10.2 deaths per 1000 live births. The black infant mortality rate of 15.0 is more than twice that of the rate of 6.9 for white infants (See Figure 4). Disparities in the infant mortality rate are seen when looking at the nine different regions of the state (See Figure 5). These disparities are reflective of differences in socioeconomic status and resource availability throughout the State with the poorer and more rural northern and central portions of Louisiana having worse indicators.

One of the factors associated with Louisiana's increase in the infant mortality rate is an increase in the low birth weight rate. From 1992 to 2002, the percent of low birth weight infants weighing less than 2500 grams increased from approximately 11% from 9.4 % to 10.5% and the percent of very low birth weight infants weighing less than 1500 grams increased 16% from 1.8% to 2.1%. The ethnic disparity in the infant mortality rates is reflected in the differences in the low and very low birth rate percentages for white and black infants - 7% of white infants were low birth weight compared with 14.4% of black infants and 1.4% of white infants were of very low birth weight compared with 3.7% of black infants. See Figures 6 and 7 of the attachment, as well as Section II, Outcome Measures Narrative for more information on infant mortality and racial disparities in infant mortality.

While child mortality in Louisiana had been decreasing, there was an increase in the mortality rate for children from 1 to 14 years of age in 2002. This ranks Louisiana 47th among the States in its child death rate. Unintentional injuries, particularly motor vehicle crashes, are the leading cause of deaths in this age group. It ranks 46th for violent deaths by accident, homicide, and suicide for adolescents from 15 to 19 years of age. Violent deaths in both age groups disproportionately affect black children except for suicide.

According to the 2000 census, Louisiana had the fourth highest percentage of children aged 5 to 15 with a disability (7%). This compares to the national rate of 5.8%. In Census 2002, children aged 5 to 15 were considered to have a disability if one or more of the following long-lasting conditions was reported: sensory disability, physical disability, mental disability or self-care disability. Louisiana disability rates for males and females aged 5 to 15 were 8.8% and 5.1% respectively. In comparison, the disability rates for US males was 7.2% and females 4.3% for the 5 to 15 age population. In Louisiana, mental disability was reported for 5.5%; sensory, physical and self-care disabilities were reported for 1.3%, 1.3% and 1.1% of the 5 to 15 age group, respectively. Louisiana 5-15 age disability rates by race and ethnicity: 6.6% for White, 7.3% for Black or African-American; 8.3% for the combined categories of Asian, American Indian/Alaska Native, Native Hawaiian/Other Pacific Islander, some other race alone and two or more races; and 6.4% for Hispanic or Latino.

In addition, information from the 2001 SLAITS Survey for Children with Special Health Care Needs ranked Louisiana fourth highest of all the states for CSHCN. This data indicated that 15.6% of Louisiana children have special health care needs, which is higher than the national average of 12.8%. For those Louisiana families of CSHCN in the SLAITS survey, 85.5% indicated that their child received SSI, compared to the national survey response of 70.7%. 2002 SSI data shows that 23,920 children under age 16 in Louisiana received SSI. This is an increase of 920 children from the 2001 Louisiana SSI count of 23,000 for this age group. Since persons with disabilities use significantly more medical services than those without disabilities, the high prevalence of disabilities among children in the state, coupled with the fact that the percent of uninsured children in Louisiana is approximately 20%, indicates a

tremendous need for health care services and resources for children with special health care needs

d. Access to health care
Louisiana has had one of the highest rates of uninsured population in the nation. According to the American Academy of Pediatrics estimates of uninsured children in 2002, 12.4 % of Louisiana children age through 18 years of age were uninsured which compared favorably with the national estimate of 11.9%. However, approximately 73% of the remaining uninsured children were income eligible for Medicaid benefits.

Financial accessibility to health care for low income mothers and children has been through the State Medicaid Program. During the State Fiscal year 2001--2002, 909,912 Louisianans were recipients of Medicaid services. This represents roughly 22.1% of the population. The percentage of Louisiana's population on Medicaid has increased from the high of 18% in 1993. In 2002, 609,503 or 67% of the Medicaid enrollees were under 21 years of age.

The State Medicaid Program has improved financial accessibility to health care for the MCH population through expansion of Medicaid eligibility for children as well as pregnant women. Improved access for children has largely been through the implementation of the State Child Health Insurance Program, LaCHIP. Louisiana's Child Health Insurance Program (LaCHIP) began on November 1, 1998, as a Medicaid expansion with a phase-in of income level eligibility to 200% of Federal Poverty Level (FPL) to age 19 on January 1, 2001. This program has been successful in increasing the numbers of children on Medicaid not just for the LaCHIP expansion but also for regular Medicaid. Since its inception, enrollment numbers have exceeded expectations with an increase of nearly 312,000 children from birth to 19 years of age enrolled in the Medicaid Program. As of March 2004 there were 630,035 Medicaid enrollees through Medicaid/LaCHIP. Along with this, the percent of uninsured children in Louisiana has decreased from an estimated 22% in 1997 to 12.4% in 2002. Most recently (January, 2003), income eligibility for pregnant women was increased from 133% to 200% of FPL.

Reasons for the success of LaCHIP include steps to streamline the eligibility process: 1) a simple, one page application form was created for both LaCHIP and Medicaid for children; 2) 12 month continuous eligibility was initiated; 3) the need for a face to face interview was removed and mail in applications are now accepted; and 4) a Central Processing Office was established to handle all child applications for Medicaid/LaCHIP. Medicaid has relied on regional outreach teams of existing Medicaid field staff to spearhead community-based outreach strategies statewide. Other steps taken since the beginning of the program include: 1) streamlining the LaCHIP/Medicaid recertification form, which is sent out to families after 12 months to re-apply for their children; 2) elimination of the three-month wait period after losing private health insurance before families can apply for LaCHIP; and 3) translation of the application form to Spanish and Vietnamese.

To address accessibility of services for children with special health care needs, the CSHS Program began a long range planning process in 2001 that is now conducting a statewide needs assessment in each of the nine regions. This focus of the needs assessment is to determine the resources/capacity of the region and private providers willing to provide specialty services for CSHCN. This information will form the basis for direction of future CSHS services in addressing the delivery of services to special needs children throughout the State.

e. Availability of health care
The large majority of the state is designated as a medically underserved area or having underserved populations by the Office of Primary Care and Rural Health (see Map 4 of the attachment). Availability of primary care practitioners poses a significant problem for delivery of health care in the state. As of March 2004, 56 or the State's 64 Parishes are designate a geographic or population group qualifying as a Health Care Professional Shortage Area

(HPSA) (see Maps 4, 5 and 6) by the Office of Primary Care and Rural Health.

Private sector involvement in the health care of low-income women and children has increased during the past few years due to increases in reimbursement by the Medicaid program. However, some physicians accepting Medicaid would place a limit on the number of Medicaid patients they would serve. There were also discrepancies among specialties, i.e. more private obstetrical providers accept Medicaid than private pediatricians. Pediatric sub-specialists providing care to children with special health care needs are concentrated in the teaching medical centers in New Orleans and to a lesser degree, Shreveport. There are very few located in the more rural areas of the state

Beginning in August 2001, the State Medicaid Program began a Region by Region expansion of its Community Care Program which had been operating in 20 Parishes in the State. Community Care is a primary care case management program for Medicaid recipients. Through this Program, all Medicaid recipients are linked to a health care provider who serves as the client's primary care health provider as well as their primary care case manager. The primary care case manager is responsible for ensuring that all clients receive EPSDT services although the screenings may be done by another provider. However, maternity patients are exempted from this program and may select any provider. This process was completed in December 2003.

However, in many areas of the state, there is no or limited access to subspecialty pediatric services. Unfortunately, some families whose children have more complex medical problems are finding it very difficult to appropriately utilize the private system and have returned to the CSHS Program with additional, more serious problems. Through the long range plan needs assessment, CSHS will be able to determine provider capacity, access problems and barriers to care for CSHCN in each region of the state. CSHS plans to collaborate with the LaCHIP program, providing leadership in the unique issues faced by families with children who have special health care needs. The level of reimbursement rates for Medicaid Providers are critical to health care access. CSHS will continue to emphasize the care coordination services that the CSHS Program provides and that are critical to families. CSHS has begun to work with Medicaid's KIDMED (EPSDT) Program to increase communication with primary care providers in Community Care parishes. This includes assistance from KIDMED in obtaining needed referrals from primary care physicians for CSHS services. CSHS has also begun preliminary talks with Medicaid for reimbursement for care coordination for CSHCN.

Thus, budget shortfalls affecting the financing and therefore the system of health services in Louisiana present a challenge to the MCH Program for assuring the delivery of needed MCH services to the poor, predominantly rural, low education, minority MCH population in Louisiana and to our efforts to decrease the mortality and morbidity in this population. The MCH Program has responded to this by the development of new initiatives to accommodate these changes.

3. Current OPH Priorities and Initiatives and Title V's Role

Louisiana, as one of the poorest and unhealthiest states in the nation, has the challenge of using its limited resources for the highest priority activities. Prevention services are under-funded as compared to other health care services. The Office of Public Health, through a strategic planning process, has defined its mission as follows:
- To promote health through education that emphasizes the importance of individual responsibility for health and wellness.
- To enforce regulations that protect the environment and to investigate health hazards in the community.
- To collect and distribute information vital to informed decision-making on matters related to individual, community, and environmental health.
- To provide leadership for the prevention and control of disease, injury, and disability in the state.

- To assure universal access to essential health services.

Operating within the context of the Office of Public Health and the changing health care environment, the Title V Program maintains its commitment to decreasing mortality and morbidity and assuring access to primary and preventive health care services for Louisiana's maternal and child health population including those with special health care needs.

For the MCH Program, the development of program initiatives has evolved into a process where data is collected, analyzed, and synthesized with knowledge on best practices to determine what would work best in Louisiana's unique environment. Program directors and epidemiologists review birth and death statistics, Pregnancy Risk Assessment Monitoring System (PRAMS) data, Infant and Child Death Review panels' recommendations, Medicaid E.P.S.D.T. reports, and other sources of information to determine the priority of competing factors impacting the health of pregnant women and children. Most data is analyzed by race and parish to determine racial or geographic disparities and trends in health status. Leading causes and associated factors of maternal, infant, and child death are reviewed and interventions are identified and implemented to address these problems. Every five years MCH coordinates a community based assets/needs assessment, obtaining input from public health and community leaders from each parish in the state. OPH Staff are working with community partners to conduct the up-coming needs assessment according to a format developed by MCH. This needs assessment will be submitted to regional OPH Medical Directors and Administrators who will work with state MCH directors to identify areas needing maternal and child health services and to identify resources to meet the identified needs. This process provides MCH staff with additional information by which to determine priorities and allocate resources.

CSHS began a plan of program review in 2001 by establishing a Long Range Plan Advisory Committee with statewide stakeholders including parents, private and public health care providers, elected officials, CSHS medical providers and local staff and OPH Preventive Services Program staff. The goal of the Long Range process was to improve the CSHS program by providing Medical Home and subspecialty clinical services by private providers in the community and monitoring, quality assurance and care coordination services to be provided by specialized OPH staff, where feasible. The committee reviewed current CSHS services and also models of services from other state CSHCN programs. Committee recommendations included: (1) Perform a needs assessment in each region to determine the resources/capacity of that area and private providers willing to provide specialty services and the barriers to care; (2) meet with major pediatric health care providers to investigate barriers to care and determine capacity to provide services statewide; (3) perform a program financial analysis in conjunction with recommendations from the needs assessment to determine a projected budget and expenditures for block grant funds; (4) collaborate with other state agencies, private providers and families to address barriers to community-based, comprehensive care; (5) develop and publish rules and regulations to implement changes in program; (6) determine contract specifications in compliance with Federal mandates, 2010 goals and maintaining an interdisciplinary team model of delivering services; (7) negotiate contracts/develop Requests for Proposals (RFPs) for providers to take over clinical services; (8) develop and implement a comprehensive quality assurance and monitoring program for system of services to include family input and satisfaction with services; (9) train specialized OPH staff in monitoring, quality assurance and care coordination activities; (10) develop and implement outreach plan to inform families, providers and public about service delivery model; (11) communicate Long Range Planning developments frequently throughout the process; (12) complete transition to new model of service delivery; and, (13) continue to advocate with major health care providers in Louisiana for improvements to the system of health care for CSHCN. At present, CSHS has contracted with Louisiana State University Health Sciences Center to perform the statewide needs assessment. This process should take 15 months and be completed by August 2004.

Another priority of OPH is the Part C/Early Intervention System. This program transitioned from the Department of Education to the Department of Health and Hospitals July 1, 2003. Monitoring reports from the Office of Special Education (OSEP) had noted problems with the Louisiana system of Part C services. OSEP data showed that Louisiana was only serving about 2% of the birth to three year population. Further monitoring issues included a lack of providers, waiting lists for services and late referrals into the system. CSHS has implemented a new system of services which include contracting with agencies to provide Systems Points of Entry, billing which utilizes a Central Finance Office and serving families in their "natural environments." Goals are to increase participation from the current caseload of 3800 to at least 5800.

CSHS provided funding to support the Louisiana Health and Disability Project Surveillance Committee. This committee is composed of professionals and parents representing a wide variety of systems for children with special health care needs: Department of Education, Louisiana Assistive Technology Access Network, Office of Mental Health, Louisiana State University Health Sciences Center, Bureau of Community Supports, Office for Citizens with Developmental Disabilities, The ARC, Family Voices of Louisiana, Part C State Interagency Coordinating Council, Governor's Office of Disability Affairs, Louisiana State Planning Council on Developmental Disabilities, The Children's Cabinet, Head Start, numerous OPH programs, several non-profit disability support groups, as well as parents from the private sector. The purpose of the committee is to develop infrastructure and build capacity to monitor, characterize and improve the health of Louisiana's children with disabilities aged 0 to 5. The goal of this committee is to: (1) conduct an inventory of state and national data sources/systems relevant to the health and Healthy People 2010 Chapter 6 status of the target population; and (2) compile a data book summarizing existing information and associated recommendations to address information gaps and data quality concerns. These activities will assist in developing the state plan for health promotion and prevention of secondary conditions for Louisiana's children with disabilities aged birth through 5. At present the committee has completed the inventory of relevant data sources and systems.

Thus, the Title V Program addresses each aspect of the OPH mission for the maternal and child population, including children with special health care needs, in the following ways:
- Health promotion is a major priority of the Title V Program, and includes public information and media campaigns on domestic violence, child abuse, prenatal care, HIV, SIDS, and injury prevention. Public health staff provide health education and counseling to 129,000 pregnant women and children each year in individual patient counseling or group sessions.
- Some of the health hazards addressed by the Title V Program include lead poisoning, car safety and other injury prevention, and child care health and safety.
- The Title V Program shares vital statistics information widely as well as information from the Pregnancy Risk Assessment Monitoring System (PRAMS) which began in 1998. The Child Death Review process informs legislators and policymakers on the needs of children and families in the state.
- The Title V staff lead and participate in various task forces related to the health of women and children, including child abuse prevention, domestic violence, perinatal care, childcare health and safety, child death review, oral health, injury prevention, and birth defects. Title V works with professional and advocacy organizations to promote legislation and regulations to protect and promote the health of women and children.
- Through its system of parish health units and school-based health centers, Title V is able to provide a statewide safety net of direct health services for women, children, and adolescents who are uninsured or have no access to other health care providers. With the largest number of poor children of any state, Title V resources continue be dedicated to direct health care services. Children with special health care needs have access to a comprehensive, family-centered, community-based network of pediatric specialists, including physicians, nurses, social workers, and other health care providers throughout the state through the CSHS clinics and community based services.
- "Every Child Deserves a Medical Home" is a priority of the CSHS program. CSHS Central

Office and OPH Regional staff have participated in several regional presentations of the AAP program, "Every Child Deserves a Medical Home." This initiative included the formation of regional committees to address the issue of primary and preventive health care of CSHCN within the specified area of the state.//2005//

B. AGENCY CAPACITY

/2005/The State Title V Maternal and Child Health Program is housed in the Office of Public Health (OPH), Department of Health and Hospitals (DHH). The mission of DHH is "to protect and promote health and to ensure access to medical, preventive, and rehabilitative services for all citizens of the State of Louisiana. The Department fulfills its mission through direct provision of quality services, the development and stimulation of services of others, and the utilization of available resources in the most effective manner." The other agencies under the Department include the Office of Mental Health, Bureau of Health Services Financing (Medicaid), Office for Citizens with Developmental Disabilities, and the Office for Addictive Disorders. The Assistant Secretaries for each of these Offices meet weekly to collaborate and coordinate services for the citizens of Louisiana.

Personal health services and local public health functions are provided by 70 OPH parish health units distributed throughout the state, except in New Orleans and Plaquemines Parish, which have their own independent health departments (See Map 1 of attachment for map of parish health units). OPH has nine Regional Administrators who supervise the health units, regional CSHS clinic sites, and regional health staff in their respective regions. The MCH Adolescent School Health Initiative provides funding and technical assistance to 51 contract school-based health centers, and 1 federally funded school-based health center.

Pregnant women and children, ages 0-21, who have no access to prenatal or preventive health care in the private sector, are served in MCH funded clinics whose services are linked with WIC, Family Planning, and Sexually Transmitted Disease services. Program directors at the state level meet regularly to coordinate these programs so the services will be "seamless" at the local level. MCH services are available in every parish in Louisiana. Orleans Parish operates an independent health department and receives support from the Title V Program. MCH provides funding to the New Orleans Health Department for an MCH medical director, a nurse consultant, and an MCH epidemiologist. MCH services are also provided through other medical and social services entities. Plaquemines Parish operates a clinic which provides EPSDT, immunization, and WIC services.

CSHS provides family-centered, community-based, coordinated care for children with special health care needs and their families, including rehabilitation services for children receiving SSI benefits, through its network of 300 pediatric subspecialty providers and facilities at the regional and local levels. Parents acting as family liaisons enhance the care coordination provided by the CSHS regional team and provide needed support.

CSHS has implemented a Long Range Plan to improve the system of services to CSHCN and their families in Louisiana. The goal of this process is to enhance community-based, private provider Medical Home and subspecialty clinical services. As CSHS strives to facilitate the development of systems of care for families, services are being merged with existing facilities or moved to local sites to complement the already existing service network established by the staff. CSHS has already begun the process of transitioning some clinical services to community private sub-specialists in the New Orleans and Alexandria areas. CSHS has also been working with the AAP to work with local communities on capacity of primary health care services for CSHCN by facilitating Medical Home trainings statewide.

In 2001, eight of the nine CSHS regional clinics were moved and consolidated into parish health units. CSHS patient visits decreased 16% in 2002 from the 2001 visit count. Some CSHS services have been reduced due to difficulty finding physicians to provide community-based services. The CSHS Long Range Plan Needs Assessment will endeavor to identify the capacity of private providers to serve CSHCN statewide and facilitate linkage of children and families to services.

The Hearing, Speech and Vision Program (HSV) also experienced layoffs of over half of the field staff. This cut has effectively eliminated vision screening services for children and significantly reduced audiological screening for children, including diagnostic and clinical services to CSHCN. The HSV Program has facilitated the transition of vision screening training to private contractors, including the Lions Eye Foundation and other individual private providers. Audiology services are still provided by remaining staff and have been reduced by 50%. Presently, services are those for infants, toddlers and medically indigent children with hearing loss. Regional audiologists have performed regional needs assessments regarding available audiological services. The findings will be incorporated into a strategic plan for the HSV program.

Although the number of patients receiving prenatal and preventive child health services is decreasing, services provided by contract agencies continue to increase. The State Title V Maternal and Child Health (MCH) Program has been able to shift significant resources from the funding of local parish health unit personnel to contract agencies, targeting services and areas of highest need as identified in the 2000 MCH Needs Assessment and other current maternal and child health data. This shift is due in part to the downsizing of the Office of Public Health parish health unit infrastructure and the new priority setting of parish health unit services to be offered to the public. In the past few years there has been a dramatic increase in Medicaid coverage of the maternal and child population in Louisiana through the Child Health Insurance Program, LaCHIP and LaMOMS (pregnant women coverage), expanding eligibility to 200% of the federal poverty guidelines. This health coverage and the statewide expansion of Community Care, Louisiana's Medicaid Managed Care system using a primary care case manager model has reduced the need for MCH to provide direct medical services in most areas of the state. The high priority services being delivered by the parish health units include WIC, Family Planning, Immunization, Tuberculosis Control, and Sexually Transmitted Diseases Programs. These Programs have greater difficulty finding community providers with whom to contract. Maternity services are still provided in parishes without obstetric medical providers.

However, with a high poverty rate and its associated health problems, Louisiana's pregnant women and children continue to fall at the bottom of most studies that rank the states according to their population's health status. MCH is targeting areas of the state with the worst infant mortality problem by providing preventive and primary care services for pregnant women and infants. Contracts with health and social service agencies have been developed and services initiated to improve the health status of this population in Shreveport, Alexandria, Baton Rouge, Lake Charles, Monroe and Orleans, Terrebonne, Jefferson and St. Tammany Parishes. The Lafayette initiative should begin by the end of this fiscal year. Services include fetal-infant mortality review (FIMR) including a community advisory committee for needs assessment and strategic planning, prenatal clinical services, outreach, and case management including the evidenced based intervention, Nurse Family Partnership home visiting program. In some of these locations, the contract agency is the Louisiana State University Health Sciences Center (LSUHSC) that administers the services at the nine regional state operated hospitals in the major metropolitan areas of the state. The state hospitals and LSU have a long history of providing services to the low-income population.

In addition, MCH provides supplemental funding in the three Healthy Start Program areas in order to provide comprehensive services for this high-risk population. Six social worker case managers were added to the New Orleans Healthy Start Program this year. A contract with the Medical Center of Louisiana in New Orleans has been established to address the finding in the

New Orleans' FIMR that 25% of the infant deaths reviewed had maternal substance abuse involved. The perinatal substance abuse prevention/case management project being implemented is based on Ira Chasnoff's model, which utilizes a comprehensive evidenced-based approach. A similar intervention was initiated this year in Monroe through an interagency collaboration between MCH, Office of Addictive Disorders, LSUHSC, and the Office of Mental Health. Louisiana has among the highest rate of low birth weight in the nation. PRAMS analysis showed that smoking and inadequate weight gain in pregnancy were the primary risk factors for low birth weight. MCH addresses gaps in smoking cessation services for perinatal populations through a contract with the American Cancer Society. The American Cancer Society utilizes the Make Yours a Fresh Start family program, a comprehensive smoking cessation program for perinatal populations. MCH contracts with an advertising agency to administer the Partners for Healthy Babies campaign. This is an outreach effort to link women with prenatal care and promote healthy behaviors. The program utilizes multiple partnerships, media messages, a toll-free information and referral hotline and other promotional activities to reach pregnant women and impact the determinants of low birth weight and infant mortality. This year, proper weight gain was one of the primary media messages.

MCH educates women in New Orleans about AZT therapy for HIV-infected pregnant women and the importance of knowing one's HIV status through a contract with Family, Advocacy, Care and Education Services (FACES). This is accomplished by education and outreach activities that target women of childbearing age. MCH meets regularly with the HIV Program to plan approaches to address perinatal transmission of HIV.

Infant death data, PRAMS information, and FIMR studies show SIDS and prone infant sleeping position to be a problem in Louisiana. The MCH Program contracts with Tulane University School of Medicine, Pediatric Pulmonary Section, for the position of Sudden Infant Death Syndrome (SIDS) Medical Director. This partnership has allowed improved MCH Program state capacity to identify, counsel and follow-up families of SIDS infants and monitor the functioning of the overall program. The MCH Program staff includes a SIDS Program Coordinator who conducts state and community-based education on SIDS risk reduction, including a statewide media campaign.

To improve Louisiana's low breastfeeding rate, MCH has a contract with Woman's Hospital Lactation Consultant Program to provide 24-hour coverage of a hotline for breastfeeding information and support.

MCH is targeting the leading causes of child morbidity and mortality by providing preventive and primary care services for children. Comprehensive preventive child health services, including physical examinations, laboratory and other screening procedures, immunizations, nutritional assessments and counseling, health education, and WIC services will continue to be provided in parish health units for children whose families are uninsured or are Medicaid eligible and have no access to private care. WIC services, immunizations, psychosocial risk assessment, and health and parenting education will continue to be provided in parish health units to patients referred by other health providers. MCH has a contract with Medicaid to conduct EPSDT screening in parish health units. Although private provider participation has decreased the number of children screened by MCH, there are still areas of the state where access is a problem and EPSDT services in parish health units continue to exist. MCH funds will continue to contract with agencies to provide support to community-based child health programs such as St. Thomas Health Services, Inc. in New Orleans and the LSU Health Sciences Center-Shreveport Tots and Teens program, which provides pediatric primary care.

Through an interagency agreement with the Office of Community Services (Child Protection Agency), MCH utilizes public health nurses to assist child protection workers in investigating suspected cases of medical neglect, malnutrition and failure to thrive. Nurses assess the child in the clinic or home within 24 hours of request.

MCH funds a child abuse prevention public information campaign through a contract with Prevent Child Abuse Louisiana (PCAL), the State chapter of Prevent Child Abuse America. The campaign includes a media campaign that promotes the PCAL toll-free counseling hotline for parents and a speakers bureau.

The state mandated Newborn Screening and Follow-up Program ensures that all newborns are screened before discharge from the hospital and again at the first medical visit, if the baby was initially screened before 48 hours old. The newborn screening battery consists of tests for the detection of Phenylketonuria (PKU), congenital hypothyroidism, hemoglobinopathies (sickle cell disease), biotinidase deficiency, and galactosemia. For infants with abnormal tests, Genetics Program staff assist the primary medical provider through the follow-up process to ensure timely and appropriate confirmatory testing and if determined to be diseased, treatment. The Genetics Program follows patients for specific time periods depending on their disorder. Contracts with three Louisiana medical schools will continue to provide laboratory testing and specialized clinical services for these patients.

MCH currently funds four home visiting programs using paraprofessional staff through contracts with social service agencies in four parishes: Ouachita, Calcasieu, Iberia, and East Baton Rouge. These programs are based on the Hawaii Healthy Start and Healthy Families America program models. However, due to recent research and a growing body of research and knowledge in the area of infant mental health and child outcomes, it has become clear that a more focused health/mental wellness intervention needs to take place to impact those children and mothers at greatest risk.
Therefore, the Best Start Program, a therapeutic health/infant mental health intervention, utilizing a nurse, social worker and case manager will provide 8-10 week small group interventions during the prenatal, newborn and toddler periods to the same populations in those parishes. Limited home visitation and ongoing treatment for mother-infant dyads in need of those services will be available on a limited basis.

MCH also funds nurse home visiting programs that follow the model for first-time mothers of low socio-economic status, entitled Nurse Family Partnership (NFP). Nurse visitors follow program guidelines that include regular visits to the family starting prior to twenty-eight weeks gestation until the child is 2 years of age. Nurses provide health education, referrals, case management and other support to women during and after their pregnancies, and their baby. Initiated in 1999 in four regions, the program now provides services in all regions of the state, including 18 parishes. Services are delivered in Region I (Jefferson Parish), Region II (Baton Rouge), Region III (Terrebonne and LaFourche parishes), Region IV (Iberia, St. Martin, Lafayette, and Vermilion parishes), Region V (Calcasieu, Beauregard and Allen parishes), Region VI (Rapides parish), Region VII (Caddo Parish), Region VIII (Franklin, Morehouse, Ouachita, and Richland Parishes), and Region IX (St. Tammany Parish).

MCH provides partial funding for the implementation of an infant mental health program, Healthy Beginnings, housed in a public health clinic in New Orleans. This pilot project is funded primarily from a local private foundation, the Institute of Mental Hygiene, through Tulane Department of Psychiatry. This project is a collaborative effort between MCH, the New Orleans Health Department (NOHD), Children's Bureau, a nonprofit mental health agency in New Orleans, Tulane University Department of Psychiatry and the state Office of Mental Health. The goal is to develop early intervention services for infants and young children below age 6 and their families with behavioral, emotional, and social problems that interfere with appropriate growth and development.

MCH funds Louisiana's SAFE KIDS program, a comprehensive injury prevention program that organizes local chapters throughout the state, distributes newsletters and pamphlets, conducts special events, and participates in health fairs. Interventions address car, gun and fire safety, childproofing homes, bicycle helmet use, and sports injury prevention. To

implement stronger prevention efforts, the MCH Program has established Regional MCH Injury Prevention Coordinators through contracts with social service agencies. These coordinators work to decrease unintentional injuries in children in each of the nine regions to establish and coordinate a region wide system of childhood injury prevention initiatives targeted at preventing injuries in children focusing on the most common causes of injuries in their areas. These Coordinators provide general child safety education and program development through coordinated efforts of MCH, EMS, Injury Prevention Programs and the local SAFE KIDS Coalitions and Chapters. They also provide support to local Child Death Review Panels.

MCH administers the Child Care Health Consultant Program by training, certifying, and facilitating the work of 160 health professionals who provide consultation and training on health and safety for childcare providers statewide. Contracts with the three Resource and Referral Agencies in the state promote the Child Care Health Consultant Program by coordinating the three hours of health and safety training conducted by MCH certified Consultants as required by Child Care Licensing in the Department of Social Services. Social and emotional health will be incorporated into this program's efforts.

MCH will continue to provide supplemental funding to the OPH Family Planning Program, which provides comprehensive medical, educational, nutritional, psychosocial and family planning services to adolescents and adults. MCH funds the Teen Advocacy Program in Baton Rouge, a community-based case management program for pregnant and parenting teens.

MCH funds the Louisiana Adolescent Suicide Prevention Task Force to develop and implement a Louisiana statewide plan on adolescent suicide prevention. MCH contracts with social service agencies to provide training on suicide prevention to school personnel statewide.

The Adolescent School Health Initiative Program will continue to collaborate with the Department of Education (DOE), the Office of Mental Health (OMH), the Office of Addictive Disorders (OAD) and the Excellence in Health and Education Project (EHEP) at Southeastern Louisiana University. Goals of the collaboration include providing state-of-the-art teaching and learning opportunities, advocating for the health and well-being of individuals in schools and communities, conducting research and evaluating services, and establishing a clearinghouse of resources for coordinated health and education.

CSHS provides rehabilitation services for CSHCN in nine clinic sites statewide, including services to children receiving SSI. 5,548 children were followed with 17,578 clinic visits in CSHS clinics in 2002 and 5711 children in 2003 with 18,327 clinic visits. In 2001, CSHS served 6.1% of the under the age of 16 SSI population. Due to changes in the Medicaid identification system, CSHS did not have an actual count of SSI clients during 2002. However, there has not been a reduction in CSHS community-based clinical services offered to children, including those receiving SSI.

CSHS funds a specialty Dental Clinic for children with special health care needs in the New Orleans area. Services are provided by LSU School of Dentistry (LSUSD) and are specially designed to be readily accessible to this population, known to have barriers to accessing regular dental care. CSHS provides assistance through DHH/OPH Regional Offices for non-Medicaid eligible children to receive routine dental services through the private sector.

The CSHS Program provides parent support through all clinic team members including nurses, social workers, clerical staff, physicians, nutritionists, audiologists, other allied health staff and Parent Liaisons. Parent Liaisons organize and participate in support groups for families of CSHCN. The number of support groups will be increased during the next five years due to identification by CSHS families as the top need. In addition, the CSHS Parent Liaison staff work with the CSHS staff in identifying and incorporating culturally appropriate services to the diverse population served in CSHS clinics. Parent Liaison staff have provided community programs on cultural diversity and continue to work with families to identify better ways to

improve services to families.

CSHS care coordination is family-centered and supportive of the child and caregiver needs through a plan that improves the quality of life by providing family support and enhancing family well-being. The inclusion of transition services into care coordination supports the self-determination and independence of adolescents with CSHCN.

As of July 1, 2003, DHH became the lead agency for the Part C/Early Intervention Program. This system transitioned from the Department of Education, which had been the lead agency since 1986. CSHS has worked with agencies statewide to build the system capacity to provide quality early intervention services for infants and toddlers with developmental disabilities. DHH has established interagency agreements with the Department of Education/Special Populations, Office of Health Services Financing (Medicaid) and Office of Citizens with Developmental Disabilities to provide funding for Part C services. CSHS will also continue to work with other agencies to access additional funding, which will increase the capacity to serve infants and toddlers with developmental disabilities. In the first year of implementation, the number of children identified increased by 40% due to the longstanding emphasis on early identification within the Office of Public Health and the MCH and CSHS programs.

State legislation in 1999 established the Birth Defects Monitoring Network. CSHS is planning to hire the birth defects surveillance staff in August 2003 and the monitoring system will become functional later in the year. Parents of children identified through the system will be offered information and referral to health care systems, as appropriate to their child's identified birth defect.

The Early Hearing Detection and Intervention (EHDI Program), within the Hearing, Speech and Vision Program, works closely will all birthing hospitals in the state to ensure hearing screening for all newborns. Newborn hearing screening results are reported on the electronic birth certificate. The EHDI program matches initial hospital hearing screening and follow-up results and is able to identify infants that have not had a screening test. Follow-up is provided for all infants with an abnormal newborn hearing screening, as well as infants that have not had a screening test. EHDI staff provided training and technical support to hospital personnel and also work with private providers to facilitate follow-up hearing evaluations.

CSHS funds a clinic at University Hospital in New Orleans to provide developmental services to children of mothers who are substance abusers. In addition to assessments, families are assisted with information, referral and follow-up to programs and agencies as determined by the needs of the child and family.

CSHS funds a program for specialized care of children with diabetes at Children's Hospital in New Orleans. This goal of this multidisciplinary program is to reduce emergency room visits, improve growth and development of the children, as well as decrease the average blood glucose level of the enrolled children.

The Louisiana Medical Home project under CSHS has participated in the National Medical Home Learning Collaborative. It currently funds a care coordinator for 2 pediatric practices in the state.

The following State statutes are relevant to the Title V program:
1. LSA-R.S. 46:971-973 - Administration of MCH Services in State of Louisiana - Health Department Responsible
2. LSA-R.S. 17:2111-2112 - Vision and hearing screening - Health Department and Department of Education Responsible
3. LSA-R.S. 33:1563 - SIDS autopsy; reporting to Health Department Required
4. LSA-R.S. 40:1299 - Mandated Genetics - Newborn screening - Health Department Responsible

5. LSA-R.S. 40:1299.111-.120 - Children's Special Health Services - Health Department Responsible
6. LSA-R.S. 40:5 - State Board of Health authority to create MCH & CC Agency
7. LSA-R.S. 40:31.3 - Adolescent School Health - School Based Clinics - Health Department Responsible
8. LSA-R.S. 46:2261 - The Identification of Hearing Impairment in Infants Law - Health Department Responsible
9. LSA-R.S. 40:31.41-.48 - The Births Defects Monitoring Network - Health Department Responsible//2005//

C. ORGANIZATIONAL STRUCTURE

/2005/The Department of Health and Hospitals is one of twenty departments under the direct control of the Governor. The State Health Agency, the Office of Public Health is one of the five major agencies within the Department of Health and Hospitals (DHH). The State Medicaid Agency, Bureau of Health Services Financing, is also located in this Department as well as the Office of Mental Health, Office of Addictive Disorders and the Office for Citizens with Developmental Disabilities. The Title V programs, the Maternal and Child Health Program and Children's Special Health Services, are located in the Center for Preventive Health in the Office of Public Health, along with Family Planning, Nutrition, Genetics, Tuberculosis Control, Immunization, Sexually Transmitted Diseases and HIV/AIDS, and Adolescent and School Health Programs. The organizational charts in Figure 1 of the attachment illustrate the structure of the departments under the Governor, DHH, Office of Public Health, Center for Preventive Health, MCH, and CSHS.

The Children's Cabinet in the Office of the Governor provides a monthly forum for the Secretaries of the child serving departments to meet and address the needs of children in Louisiana. The Children's Cabinet Advisory Board consists of the Assistant Secretaries of the agencies within the departments that serve children, as well as non-profit and advocacy organizations. This Board meets monthly and makes recommendations for policy, program development, and funding for child issues. MCH is represented on subcommittees of the Board. The Early Childhood Comprehensive Systems grant is being administered as a joint project of the Children's Cabinet and the MCH Program.

The Office of Public Health is organized into five centers, Center for Preventive Health; Center for Environmental Health; Center for Health Policy, Information, and Promotion; Center for Administrative and Technical Support; and Center for Community Health. The Center Directors, Program Directors, and Regional Directors meet regularly and the Program Directors in the Center for Preventive Health meet as a separate group monthly. The MCH and CHSCN Program and Medical Directors are the individuals primarily responsible for administering the programs funded by Title V. These staff report to the Director of the Center for Preventive Health, who in turn reports to the Assistant Secretary of OPH. The Directors of the Family Planning, Immunization, and Adolescent and School Health Programs are responsible for the proper administration of the Title V funds allocated to these programs and provide to the Title V Director annual reports and plans related to their particular performance measures.

MCH conducted an internal assessment of its organizational structure during this fiscal year. Fifteen lead MCH staff members attended a 4-day assessment and planning process, facilitated by a local consultant. Needs identified included new positions, staff recruiting, orientation, and retention, mentoring programs for new staff, communication and collaboration, contract development and monitoring, and physical space. A strategic plan was developed and subcommittees were formed to address each of these areas. As a result, a new orientation process was implemented for all new staff including a manual; a mentoring program was developed; new positions and vacancies were all filled or are in the process of being filled; a contract manual and training module was made available to all MCH staff; a

physical space plan was developed and a work order has been processed. To address the communication/collaboration needs the MCH Program was re-structured by population and functional areas including Maternal Health, Child Health, Nurse Family Partnership, Epidemiology, Health Education, and Mental Health. The Team Leaders for Maternal Health, Child Health, Nurse Family Partnership, Epidemiology, and Mental Health meet with the MCH Director and assistant MCH Director every other week for a MCH Management Team meeting to foster collaboration among these programmatic and functional areas and to keep the MCH Director and each other informed. The Team Leader for Health Education meets with the health education team once a month and with the MCH Director once a month. The Maternal Health, Child Health, and Nurse Family Partnership Teams meet separately once a month and the Epidemiology Team meets weekly. The CSHS staff has undergone a rapid expansion with the addition of the Part C program and new staff dedicated to early interventions. CSHS staff meets monthly and individual work units, such as Early Steps (Part C), Hearing Speech and Vision, and Birth Defects meet as needed. The CSHS administrative team of Program Manager, Medical Director, Nurse Consultant, Social Work Consultant and Parent Consultant meet frequently and policy issues and to approve special requests for services.

The Nurse Family Partnership (NFP) team meets quarterly with the supervisors of the OPH and contract sites and conducts annual training with all NFP nurses. State MCH staff spends a great deal of time providing consultation and technical assistance with other public agencies, contract agencies, advisory boards and commissions.

The state is divided into nine administrative regions (see Map 1), with Regional Directors in each of the regions responsible for identifying and addressing the health needs of the population, assuring the quality of care, and providing monitoring and reporting of MCH services delivered through parish health units and contracts. State MCH Medical Directors and Nurse Consultants are responsible for the quality of the clinical services funded by MCH. Each contract funded by MCH has an MCH staff member responsible for ongoing performance monitoring. Program and contract monitoring consists of monthly review of fiscal information and performance indicators; and quarterly to annual on-site meetings with contract agencies to determine the quality of the service. Training and technical assistance is provided on a regular basis by MCH staff.

Health status information is shared with state, regional, and local public and private health and community leaders in an effort to engage stakeholders to partner with MCH to improve the maternal, infant, child, and adolescent morbidity and mortality rates. State MCH staff provides technical assistance and consultation to help local stakeholders in assessing needs and developing plans to address the needs. MCH may provide funding to local entities or assist these groups in obtaining other sources of funding to address their maternal and child health needs.//2005//

D. OTHER MCH CAPACITY

/2005/In addition to the Regional Administrator, each region has a Medical Director, Regional Nurse Consultant, Administrative Manager, Social Worker, Nutritionist, and Regional CSHS Staff. Although policy development and programmatic direction are provided by the State MCH Program staff, regional and local staff provide significant input. The State MCH/CSHS Program staff includes a Maternity Program Medical Director, Child Health Medical Director, MCH Program and Title V Director, CSHS Program Director and CSHS Medical Director. Staffing also includes a Statewide Maternity Nursing Consultant, Pediatric Nursing Consultant, CSHS Nursing Consultant, CSHS Social Work Consultant, CSHS Statewide Parent Coordinator, CSHS Statewide Part C Early Intervention Program Manager and Parent Consultant, Hearing, Speech, and Vision Program Director, Newborn Hearing Screening Statewide Parent Coordinator, MCH Assistant Administrator, MCH Nutritionist, SIDS Program Coordinator, Mental Health

Coordinator, Maternity Program Quality Assurance Coordinator, two CSHS accounting and contract monitoring staff, an Oral Health Director, a part-time Dental Consultant and Fluoridation Coordinator, three PRAMS staff, a Birth Defects Registry Coordinator, a CDC assignee MCH epidemiologist, MCH Health Education Coordinator, MCH Health Educator, Nurse Family Partnership Director, Nursing Consultant and Program Manager, Child Care Program Coordinator, Child Death Review Nurse, Adolescent Health Initiative Coordinator, Folic Acid Coordinator, Adolescent Health Medical Director, four Adolescent Health Initiative staff, and nine clerical staff. Through MCH and CDC grants, The MCH Epidemiology Program also includes a CSHS epidemiologist, an Epidemiologist Coordinator for the Newborn Hearing Screening program, two Systems Development Initiative Epidemiologists, two CDC fellows, and an MCH Epidemiologist for the City of New Orleans Health Department.

Of the State positions mentioned above, there are two vacant positions: Statewide Maternity Nursing Consultant and the MCH Health Educator. These positions are expected to be filled during July 2004.

In addition to program consultation, the CSHS Medical Director will work on special projects, such as Medical Home for CSHCN. One of the Medical Home priorities is to work with the Medical Home Learning Collaborative grant, which will enhance the capacity of Medical Home practices in the state. A medical home project coordinator and social work consultant are also under contract to enhance primary core services through the Medical Home Project. Early Steps, the Part C Early Intervention program, has added 16 new positions, including Program Manager. Seven of these positions are in Central Office and 9 positions are in the field, with one Regional Coordinator in each of the nine OPH regions. Additional positions have been requested for the 2003-04 FY, including Quality Assurance Specialists and a position for a coordinator for Part C comprehensive system of personnel development. Parent Community outreach specialists are also employed in each region as well as a full time Parent Consultant for Early Steps.

The number of OPH field staff resources (FTEs) funded by the MCH and CSHS Programs is approximately 95 and 50 respectively. As the number of staff decreases in the direct health care portions of the program, staff is being hired through contracts to initiate nurse home visiting programs across the state. Contracts are now in place to begin to build MCH services in areas of greatest need through contract agencies and institutions including medical schools, state operated and other hospitals, regional health and human service entities, and non-profit social service agencies.

Previously dedicated CSHS field staff had been integrated into the health units and cross-trained with other programs so that they can perform multiple duties. Additional health unit staff had been trained to assist in CSHS clinics. The CSHS program has provided two weeklong trainings and one clinical training for nurses to foster quality services for CSHCN.

Please refer to the attachment for brief biographies of the MCH Senior Level Management Team (Table 1).

CSHS employs parents as Family Liaisons in all 9 Regional Offices. In addition to providing one to one family support and information, the Family Liaisons promote the issues critical to families with children with special needs in local communities and at a state level. The CSHS Statewide Parent Coordinator has been instrumental in providing input to policy and establishing links with other consumer organizations at the state and national level. In addition, a position has been established for a CSHS Statewide Parent Training Coordinator to provide consistent training for and communication among CSHS Parent Liaisons.

Nine Parent Community Outreach Specialists were added in 2003 to work in the Part C Early Intervention program. These parents have gone through extensive training and will work closely with the Part C OPH Regional Coordinator. A Statewide Parent Consultant has also

been hired to coordinate the services of the Regional Part C parents and to collaborate on policy development.

To enhance MCH capacity at the regional and urban areas in order to address priority needs, staff have been added through contract agencies. Contracts have been used because there is a strict limit on the number of state employees that can be hired in the DHH agencies. In order to address injury prevention, the leading cause of child death, Injury Prevention Coordinators have been hired in each of the nine regions of the state. These staff work under the direction of the Regional Medical Director. Likewise, to address areas of high infant mortality, Infant Mortality Reduction Initiative (IMRI) coordinators have been hired in most regions of the state. Those hired as coordinators are either obstetricians or nurses. The Regional Medical Directors play a lead role in collaboration with the IMRI coordinators to conduct Fetal-Infant Mortality Review, needs assessment, and strategic planning to address infant death, prenatal care, SIDS, and the interventions to address these problems. In the three Healthy Start projects, MCH has supplemented those programs with funding for prenatal care or for enabling services such as outreach and case management or infrastructure.

In the past year or more, there has been some transitioning of WIC services at the parish health unit away from the traditional use of nurses toward increased use of health educators. MCH is working with the OPH Regional Administrators to identify opportunities to utilize the resulting time available from the nurses who will no longer work in WIC services. The MCH services that nurses will devote their time to includes psycho-social risk assessment of pregnant women and infants and referral of those at risk to social workers, case managers, or other agencies such as the Office of Mental Health or Office of Addictive Disorders. Another role for the nurses, that MCH hopes to increase, is child-care health consultant services.//2005//

E. STATE AGENCY COORDINATION

/2005/The MCH Program has a long history of extensive coordination with public and private agencies and organizations serving pregnant women and children. MCH has provided leadership in developing a focus on prevention for Louisiana, in both program and policy development. MCH involvement with the Louisiana's Children's Cabinet Advisory Committee has facilitated the Cabinet's focus on prevention. Established by the legislature in 1998 as a policy office within the Office of the Governor, the Children's Cabinet has as its primary purpose the coordination of policy, planning, and budgeting that affects programs and services for children and their families and the elimination of duplication of services where appropriate. It is composed of the Secretaries of the Departments of Social Services, Health and Hospitals, Public Safety and Corrections, and Labor; the Superintendent of Education; the Commissioner of Administration; a member of the Louisiana Council of Juvenile and Family Court Judges, and a representative of the Office of the Governor, and a representative of the Children's Cabinet Advisory Board. The Children's Cabinet Advisory Board provides information and recommendations from the perspective of advocacy groups, service providers, and parents. The Advisory Board members represent a wide variety of non-profit agencies, health and educational institutions, assistant secretaries from the Departments listed above, and juvenile court. MCH staff have served on or chaired subcommittees of the Children's Cabinet Advisory Board since its inception. The Children's Cabinet has recommended maternal and child health interventions among its top five priorities for funding, including expansion of the Nurse Family Partnership Program (MCH's nurse home visiting program) and MCH administered adolescent school based health clinics. The Early Childhood Comprehensive System (ECCS) grant is being administered as a joint venture between the Children's Cabinet and MCH/OPH.

Early in the implementation of the Nurse Family Partnership Program it became clear that the mental health needs of these first-time, poor, and often young mothers were significant. MCH requested assistance from the state Office of Mental Health (OMH) and a partnership between the MCH and the Office of Mental Health has resulted in the development of infant mental health consultation for these teams. A memorandum of agreement outlines how both agencies will coordinate services across the state. Following the successful implementation of this infant mental health intervention, the OMH received funding for an intervention to identify and mitigate the risks for young children ages 0-5 who are exposed to risk factors such as abuse, neglect, exposure to violence, parental mental illness, parental substance abuse, poverty, and developmental disabilities. Services and supports are provided to promote healthy early brain development, and to improve school readiness. The program promotes collaboration and partnership with all entities at the local (parish) level, including the local Mental Health, Public Health, Addictive Disorders, Social Services, Family Support, Developmental Disabilities, Head Start, Education, Medicaid, Housing, and Part C agency representatives as well as local pediatricians, domestic violence shelters, child care, parenting education and support providers. MCH is a key partner at the state, regional and local level.

The MCH Program has supported an interagency agreement with the Child Protection Agency for the past 11 years to provide public health nursing assessments for children under investigation by the Office of Community Services (OCS) for suspected failure to thrive, malnutrition, or other medical neglect. Regular meetings are held with regional OCS and Office of Public Health directors to keep this collaboration active and productive. Contracts targeting the early childhood period exist between the MCH Program and many entities for child abuse prevention and parent support services including a public information campaign with Prevent Child Abuse Louisiana and 4 paraprofessional home visiting programs based on the Healthy Families America model with non-profit counseling agencies.

The Prevent Abuse & Neglect through Dental Awareness (PANDA) Initiative exists in conjunction with the PANDA Coalition, which includes the Louisiana Children's Trust Fund, Louisiana Dental Association and its Alliance, Louisiana Academy of Pediatric Dentistry, Louisiana Dental Hygienists Association, OCS, and the American Society for Dentistry for Children Prevent Child Abuse Louisiana. PANDA materials are distributed to all dentists and hygienists in the state. Dentists, hygienists and dental hygiene students are educated on recognizing and reporting signs of child abuse and neglect.

MCH has contracts with a New Orleans non-profit counseling agency to provide mental health services for children exposed to extreme violence including murder, families with a loss due to Sudden Infant Death Syndrome, and at-risk families with children age 0-5. MCH provides partial funding for the implementation of an infant mental health program housed in a public health clinic in New Orleans. This pilot project is funded primarily from a local private foundation, the Institute of Mental Hygiene, through Tulane Department of Psychiatry. This project is a collaborative effort between MCH; the New Orleans Health Department (NOHD); Children's Bureau, a nonprofit mental health agency in New Orleans; Tulane University Department of Psychiatry; and OMH.

The Child Death Review Panel, established by the State Legislature in 1993, reviews all unexpected deaths in children under the age of 15. This panel includes representatives from MCH, OCS-Child Protection Agency, Coroners Association, Attorney General's Office, American Academy of Pediatrics, State Medical Society, Vital Registrar, State Police, Fire Marshall, the Legislature and the general public. The MCH Program currently staffs a full time position for the Child Death Review Panel.

The Department of Social Services, Child Care Assistance Program is a key partner with the MCH Program's Child Care Health Consultant initiative. The MCH Child Care Program Director serves on many child-care related committees addressing health, safety, and overall quality. Contracts exist between MCH and the three non-profit Resource and Referral Agencies to

promote the Child Care Consultant Program and coordinate local health and safety training for over 1000 child care centers across the state.

The Medicaid Agency, the Bureau of Health Service Financing, and MCH coordinate in program development and data sharing. MCH is a Medicaid provider of EPSDT services, prenatal care, and case management. Local parish health units determine eligibility for pregnant women to become Presumptively Eligible for Medicaid and assist pregnant women and children with the eligibility process for ongoing Medicaid and CHIP eligibility. Parish health units continue to be the largest source of applications for Medicaid/CHIP. MCH advocated for and assisted Medicaid in preparing the data and information to convince policy makers to expand Medicaid coverage for pregnant women from 133% of the federal poverty guidelines to 200% in January 2003. Starting in November 2003, this includes dental coverage for pregnant women with periodontal disease.

MCH has a memorandum of agreement with the state Office of Addictive Disorders (OAD) to provide pregnancy testing and prenatal care referral for women served by OAD. MCH provides the test kits, training, and access to services of the Parish Health Unit for pregnant women. MCH and OAD collaborate on other services for pregnant women including assigning OAD substance abuse counselors to work with perinatal substance abuse programs in New Orleans and in Monroe. MCH provides data and information to OAD for program development and grant applications.

Local parish health unit staff funded by MCH provides pregnancy testing, prenatal care and education, preventive child health services, presumptive eligibility and ongoing Medicaid eligibility assistance, and home visiting services statewide. WIC services are provided at the same time patients receive MCH prenatal and EPSDT services. Parish health unit WIC patients who receive prenatal or child health care from private providers receive health counseling, education, and referral from MCH funded staff. The state Title X Family Planning Program receives funding from the MCH Block Grant each year. Family Planning services are provided in parish health units and contract agencies statewide and are linked with prenatal services funded by MCH. Program directors of MCH, Family Planning, WIC, and other personal health programs coordinate services and program planning during regular OPH staff meetings.

New Orleans has an independent health department and MCH funds maternal and child health services including mental health services. MCH provides funding for the MCH Medical Director, MCH Nurse Consultant and an MCH Epidemiologist for the New Orleans Health Department. Six social workers were funded by MCH to expand the New Orleans Healthy Start project area. MCH funds a large prenatal clinic in a low-income neighborhood with LSU Medical School providing the clinical services and the City of New Orleans providing the facility. MCH provides funding for prenatal care and/or pediatric services in primary care centers in Orleans, St. Charles, and Caddo parishes. Prenatal clinics are funded by MCH in the three Healthy Start grant project areas: New Orleans, Baton Rouge, and rural parishes in North Louisiana.

A key provider of MCH services across the state is the Louisiana State University (LSU) Health Sciences Center. LSU administers the services of the 10 state operated hospital located in region of the state. MCH contracts with LSU in 6 of the 9 regions to provide prenatal care, nurse home visiting, case management, preventive pediatric services, Fetal-Infant Mortality Review, needs assessment and strategic planning for the maternal and child population. These activities comprise the Infant Mortality Reduction Initiative (IMRI) functions. In the remaining regions, the IMRI is coordinated by public and private hospitals, universities and social service entities. LSU Dental School collaborates with MCH to provide the Oral Health Director, Dental Consultant, and Fluoridation Coordinator to administer the state Oral Health Program.

Tulane University Health Sciences Center (TUHSC) collaborates with MCH to provide essential infrastructure services. The SIDS Medical Director is a Pediatric Pulmonary Specialist in the TUHSC Department of Pediatrics. Evaluation, biostatistics, and health communication

expertise is provided through contracts with the TUHSC School of Public Health and Tropical Medicine. Each semester at least five MPH students conduct their required internship in the MCH Program.

The MCH Director serves on the State Commission on Perinatal Care and Infant Mortality, which has been successful in establishing the framework for regionalization of perinatal services by setting standards for determining the level of services that each hospital can provide. These standards are utilized by the Hospital Licensing Section and for Medicaid reimbursement. The MCH epidemiologists present findings from birth and infant death and PRAMS data analysis at the Commission meetings to inform policy decisions.

The Adolescent School Health Initiative Program collaborates with the Department of Education (DOE), the Office of Mental Health (OMH), the Office of Addictive Disorders (OAD) and the Excellence in Health and Education Project (EHEP) at Southeastern Louisiana University. Goals of the collaboration include providing state-of-the-art teaching and learning opportunities, advocating for the health and well-being of individuals in schools and communities, conducting research and evaluating services, and establishing a clearinghouse of resources for coordinated health and education.

CSHS has taken a leadership role by uniting with some established partner organizations, private providers, parents and other stakeholders to implement a Long Range Plan to address ongoing challenges in providing services for children with special health care needs statewide and also to strategize for the future direction of the CSHS Program. Agencies and organizations that participated in this collaboration in 2001 included Children's Hospital, Tulane Hospital for Children, Shriner's Hospital, statewide Families Helping Families members, private physicians, Office of Public Health (OPH), Medical Center of Louisiana at New Orleans, state congressional staff, as well as parents and parent organization members. These organizations and individuals have participated with CSHS for many years in both services and advisory roles. As a result of this collaboration and teamwork, CSHS contracted with Louisiana State University (LSU) Health Sciences Center in 2003 to conduct a Statewide Needs Assessment that will describe the current access to health and related systems of care for the provision of comprehensive and coordinated care of children birth through 21 years in Louisiana. After completion of this needs assessment in all 9 regions of the state, CSHS will begin regional planning with local stakeholders, medical representatives, OPH staff, other agencies and parents to formulate plans for future CSHS services, as well services for all CSHCN in the community.

CSHS is also working in partnership with many agencies and organizations to address the need for primary health care services for all CSHCN in Louisiana. Since 2000, CSHS has collaborated with the Louisiana Chapter of the American Academy of Pediatrics to provide "Every Child Deserves a Medical Home" trainings in 4 sites statewide. In preparing for each of these programs, CSHS organized planning meetings with local agencies and organizations including local hospitals, private providers, Medicaid, Social Security, Vocational Rehabilitation, Department of Education, LSU Medical School, Tulane University Medical School and School of Public Health, ChildNet (Part C of IDEA), Office of Citizens with Developmental Disabilities, Agenda for Children, Families Helping Families, Family Voices, City of New Orleans Health Department, health care organizations and parents. The OPH has directed each of the 9 OPH regions to plan and implement a strategy to address the issue of adequacy of primary care providers to serve CSHCN statewide. CSHS will continue to work with each of the remaining regions of the state as they plan for Medical Home trainings and partner with local representatives to address this need in the local communities.

Louisiana has completed the process of transitioning the Part C of Individuals with Disabilities Education Act from the State Department of Education to the Department of Health and Hospitals. CSHS will administer this program within the Office of Public Health. CSHS officially assumed responsibility for administering this early intervention program on July 1, 2003.

Through the redesign of this program, CSHS convened 2 planning retreats with representatives of many state and private agencies and organizations, including the State Interagency Coordinating Council, State Department of Education, Medicaid, Office of Citizens with Developmental Disabilities, Easter Seals, Families Helping Families, LSU, University of Louisiana at Lafayette, Louisiana Case Management Alliance, Head Start, public and private hospital and health care agencies, family service coordination agencies, and parents. Members of these retreats worked on teams to assist in the redesign of the program. CSHS continues to partner with these agencies and individuals in work teams that are continuing to focus on Personnel Preparation, Service Coordination, Finance and Public Relations for the Part C/Early Intervention Program. CSHS has worked with a marketing agency to design and create a new name for the program, " Early Steps," as well as a comprehensive public education program to increase the awareness for the need for early intervention services for children with developmental disabilities in Louisiana, with a widespread campaign that began in December 2003.

In conjunction with the transition of the Part C/Early Intervention Program, CSHS is also collaborating to develop interagency agreements with several agencies. Negotiations are in progress with The Department of Education, Office of Health Services Financing, Office of Citizens with Developmental Disabilities and Bureau of Health Services Financing (Medicaid) to ensure a coordinated system of early intervention services.

CSHS has always worked in conjunction with the WIC program to facilitate referrals of eligible children from WIC to CSHS and to coordinate WIC services for CSHS clients. With the transition of the Part C program, CSHS has been closely working with WIC to establish procedures of identifying children eligible for Part C services and expediting referrals to the Part C Systems Point of Entry locations. CSHS plans to continue this ongoing partnership to assist in the identification of children and in providing services for CSHCN.

In addition, CSHS has been working in partnership with LSU School of Medicine to provide services for children of mothers who are substance abusers. CSHS funding is supporting the services of a Developmental Specialist who provides clinical services for identified children in clinics at University Hospital in New Orleans. In addition to assessments, this clinic provides information, referrals and follow-up to programs and agencies as determined by the needs of the child and family.

CSHS has also pooled resources with Children's Hospital to establish a model program dedicated to the specialized care of children with diabetes in Louisiana, with a focus on prevention of acute and chronic complications. This multidisciplinary program provides the team services of a pediatric diabetologist, pediatric diabetes nurse educator, pediatric nutritionist, pediatric psychologist, exercise trainer and visiting pediatric diabetes liaison nurse. The goal of this program is to reduce emergency room visits, improve growth and development of the children, as well as decrease the average blood glucose level of the enrolled children.

CSHS, LSU Dental School and Children's Hospital have jointly provided funding for the Special Children's Dental Clinic at Children's Hospital. Children's Hospital provides space for this clinic in the Ambulatory Care Clinic section of the hospital. LSU Dental School staffs the clinic with pediatric dentists, dental students and dental support staff. CSHS provides funding for clinical services. This clinic services CSHCN from the 9 statewide CSHS clinics, as well as private clients.

CSHS is implementing the Birth Defects Monitoring Network. CSHS formed the Birth Defects Registry Task Force in 1999 to study the feasibility of developing a birth defects registry in Louisiana. This committee consisted of representatives from the medical community, birth defects prevention agencies, Department of Education, OPH and the MCH Coalition. Legislation was passed in 1999 to establish the Louisiana Birth Defects Monitoring Network

(LBDMN). This name emphasizes partnering with other projects and agencies to ensure success of the program. The Advisory Board consists of nine members including representatives from the Louisiana State Medical Society, Ochsner Foundation Medical Center, Tulane University Medical Center, Louisiana State Medical Centers in New Orleans and Shreveport, March of Dimes, MCH Coalition, OPH, a parent representative and a consumer representative. At present, Louisiana has published rules and will hire surveillance staff for the program in a partnership with the Louisiana Public Health Institute.

The Hearing, Speech and Vision Program (HSV) within CSHS works closely with all birthing hospitals in the state to ensure hearing screening for all newborns. HSV has provided training and technical support to hospital personnel for testing, reporting data and linking families to follow-up services. CSHS also collaborates with private audiologists and the medical community for follow-up evaluations or for families with lack of insurance or no access to local community services. The State Advisory Council for Newborn Hearing Screening is appointed by the Governor and includes 14 stakeholder members and advises the program on the EHDI system in the state.

CSHS has ongoing meetings with Medicaid and KidMed to address issues related to provision of services for CSHCN. A representative from Medicaid serves on the Title V/CSHS planning team and has assisted CSHS in developing a plan of services for several years. CSHS also is negotiating an interagency agreement with the Bureau of Health Services Financing (Medicaid) to ensure a coordinated system of early intervention services for CSHCN.

The CSHS Program Manager participates in the State Planning Council for Developmental Disabilities in Louisiana. Other members of this council include the Advocacy Center, LSU-HSC Center for Excellence in Developmental Disabilities, self advocates, parents, Department of Education, OMH, Office for Citizens with Developmental Disabilities, Louisiana Rehabilitation Institute, Governor's Office on Disability Affairs, Governor's Office on Elderly Affairs and others. This ongoing collaboration addresses issues related to all aspects of life for persons with disabilities.//2005//

F. HEALTH SYSTEMS CAPACITY INDICATORS

/2005/The following is a discussion of the data collection process, limitations and proposed actions for Health Systems Capacity Indicators.

17. 1. The rate of children hospitalized for asthma (ICD-9 Codes: 493.0-493.9) per 10,000 children less than five years of age.

This data is collected from the Louisiana Inpatient Hospital Discharge Database (LAHIDD), which is administered from within the State Center for Health Statistics (CHS). FFY 2001 counts for this indicator were substantially different from those provided for previous years. Scrutiny of these gross differences resulted in a review of the previous counts provided. Different and undocumented methodologies had been employed to derive the counts for the preceding three years (1999 to 2001) by the previous LAHIDD coordinator. The new coordinator of the database re-ran the program, and provided more accurate counts for these previous federal fiscal years that were more congruent with the 2001 information.

Data sent by hospitals licensed in Louisiana to LAHIDD are for the most part, a natural by-product of hospital billing activity and are already widely available in a reasonably standard electronic format. Data is received on a quarterly basis from the hospitals. In the calendar year 2001, 85.6% of 26,281 beds in licensed hospitals in Louisiana submitted data to LAHIDD. A number of barriers hinder timely availability of the data for grant purposes, and result in information required being at least one year behind schedule. It is anticipated that the 2002 data will be available in September 2004.

17. 2. The percent Medicaid enrollees whose age is less than one year during the reporting year, who received at least one initial periodic screen.

This data is collected from Louisiana's Bureau of Health Services Financing (BHSF) office. The indicator is an established measure and is readily available on a timely basis at the end of each federal fiscal year. While some states have separate Medicaid and Children's Health Insurance Programs, Louisiana's Children's Health Insurance Program (LaCHIP) is administered from within the Medicaid office. As a result the counts provided for this indicator include Medicaid enrollees in LaCHIP. The count is based on those children receiving Early Periodic Screening and Diagnostic Treatment (EPSDT) and is therefore an undercount because it does not include Medicaid enrollees who received services other than EPSDT.

17. 3. The percent State Children's Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.

This data is also collected from Louisiana's Medicaid Office. Given that this measure is not established within the Medicaid office, information for this indicator is received on a less timely basis each federal fiscal year. The process involves making a special run of the software used to generate counts.

17. 4. The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.

This data is collected from the State's Vital Records Registry from the Certificate of Live Birth, and is prepared and received from the Center for Health Statistics. Data is usually received on a timely basis, given that the CHS usually closes out the birth data file in the late spring to early summer. Due to recent changes in procedures and regulations regarding acquisition of vital event data within the CHS, it has been taking slightly longer to get the data for analysis, in this case the 2003 data. Vital Statistics data is based on the regular calendar year.

18. 5. Comparison of health system capacity indicators for Medicaid, non-Medicaid and all MCH populations in the State

This data involves matching data from the CHS, live birth and infant death data, and Medicaid eligibility data. Due to the length of time involved in collaborating with these two entities, to match the data using confidential information, availability and analysis of this indicator is one year behind the required information for this grant.

Prior to 2001, the data linkage process involved the CHS, providing the Medicaid office with an electronic list containing the mother's social security number and the infant's year of birth. Medicaid then ran these numbers through their system to find those mother's who were eligible for Medicaid during that particular year, those who had been previously eligible but were not for the that year, and finally those who were not in the system, indicating that they were non-Medicaid mothers. This linked list was sent back to the CHS at which point the other variables usually included in the completed birth and infant death files were added to the file and forwarded to the MCH department. In the year 2001, additional variables were used in the matching processing, improving the linkage of the two databases. The additional variables included, mother's name, mother's date of birth, and infants' full date of birth.

In late 2001, the Medicaid data shifted sources. The previous company responsible for managing Medicaid data was a claims processing company under contract and provided limited communication regarding the nature of the data. These barriers in communication hindered the CHS's understanding of how the data was collected, stored, and purged. Furthermore, lack of knowledge regarding the nature of the data compromised the ability to

determine the best method of linkage. To compare methodologies, 2000 Medicaid data was linked a second time and yielded a 20% difference in identifying those eligible for Medicaid. The current data managing company stores and downloads data nightly into a Data warehouse. For 2002 data, the Office of Financial Research and Planning within DHH has access to Data warehouse data and collaborates directly with MCH. This has substantially improved the ability to identify those eligible for Medicaid.

18. 6. The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to1), children, Medicaid, and pregnant women

This data is collected from the Medicaid office. The indicator is established within that office and is therefore readily available at the end of each federal fiscal year.

18.6. The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, SCHIP, and pregnant women

This data is collected from the Medicaid office. The indicator is established within that office and is therefore readily available at the end of each federal fiscal year.

17.7. The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.

This data is obtained from the Louisiana Bureau of Health Services Financing (BHSF) on the HCFA 416 form. The data collected is broken down into this age group so this information is readily available through the Medicaid office at the end of each federal fiscal year.

17.8. The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from State Children with Special Health Care Needs (CSHCN)

This data is collected from the Social Security Administration and the Medicaid office. The Social Security Administration provides the denominator for this indicator, the number of children less than 16 years old receiving SSI benefits in Louisiana as of December 2003. The numerator was collected from the Medicaid office, and represents the number of SSI recipients 0-16 who received any service from Office of Public Health clinics. This includes services that are not specifically rehabilitation services, such as WIC and immunizations. As of SFY 2000, Medicaid moved into a new swipe card system. The new Medicaid numbers do not code for SSI recipients as before, so the previous count that was conducted on CSHS patients not receiving rehabilitative services became impossible. For SFY 2000, an attempt to collect data on SSI status by phone from the CSHS regional clinics resulted in what presents as a significant decrease of SSI beneficiaries in that year and is probably an under representation. SSI services continue to be provided as usual and provisions are to being made to re-identify this population.

19. 9.A General MCH Data Capacity: The ability of the state to assure MCH Program access to policy and program relevant information.

The State System Development Initiative (SSDI) grant enhances the data capacity of Louisiana's MCH and CSHCN programs to assure access to data that is pivotal to policy and programmatic decisions. The SSDI coordinator and data manager collaborate with the Center for Health Statistics (CHS), Financial Research and Planning, WIC, and Genetics Department, to facilitate the linkage of birth and infant death data with Medicaid, WIC, and the newborn screening program data. To date, successful linkage has been made between the vital event data and Medicaid data allowing performance of analyses that take into account the Medicaid eligibility of the population and specifically address HSCI#5.

Efforts are underway to establish linkages with the WIC and newborn screening programs. An

attempt has been made to link the WIC database to the birth file. WIC data contained a very high level of missing values for key variables required in the linking process, resulting in a match for only about 20% of the data. WIC in collaboration with MCH is working to improve the quality of incoming WIC data for further attempts at linking the databases.

In 2004, exploratory analysis of the linkage variables in the WIC file reexamined the data quality and the frequency of missing values. Specifically, the frequency of mother's social security number present in the WIC index and case files was evaluated. Analysis of the linkage variables from the WIC file revealed that 88% of mother's in the WIC case file (denotes WIC status) were matched in the WIC index file (provides demographic information including SSN) and had social security number. This has impeded developments in linking the current WIC database with Vital Record files.

Further delays are a result of changes in data systems. The current WIC PASPORT database will be replaced by the WIC PHAME and Master Patient Index (MPI) systems. The new systems are currently being designed and will be implemented by January 2005. The MPI will correlate and cross-reference computerized client records from Vital Records and WIC databases while matching key identifiers. It is anticipated that Vital Records will be reconfigured to accommodate the MPI by January 2005. As a result of the WIC database undergoing a major reconfiguration, linkage efforts are on hold until the new WIC database is put into operation.

The OPH state laboratory, conducts approximately 85% of newborn screening, while two private laboratories conduct the remainder. An attempt was made to match the birth data to the newborn screening file and from this it was determined that the match would not be adequate until quality of the data from the two private labs was improved. A rule promulgated in April 2001 by the state legislature, requires these labs to report a required number of data fields on all screening records to the OPH Genetics program, in a standard format.

A trial linkage between the Newborn Screening file and birth file was completed in April of 2004. Louisiana Newborn Screening Laboratory data was compiled from three separate laboratory files into one file. However, two of the laboratories did not report values for key linkage variables. Efforts are being made to correct these omissions in compliance with the newborn screening rule (LAC: V.6300). The newborn screening program anticipates a match between the two databases for the first quarter of the 2004-2005 federal fiscal year.

Additional efforts to enhance the data capacity of MCH and CSHCN involve the institution or receipt of information from data registries and from surveys. Direct access to 2001 LAHIDD data has been granted and 2002 data will be available in September 2004. Currently, descriptive analyses of morbidity in the MCH and CSHCN populations are underway. Furthermore, LAHIDD, which is administered within CHS, has provided the MCH program with data on annual discharges for asthma and non-fatal injuries among children.

Until last year, Louisiana did not have a system to monitor birth defects. CSHCN secured funding from CDC, which along with Title V funding will allow for the implementation of the Birth Defects Registry. In 2001, the state legislature passed a law creating the registry, which authorizes OPH to obtain reports from hospitals and other sources. The development and passage of administrative rules and regulations to ensure hospital compliance have been completed and approved (LAC 48: V.Chapters 161 and 163). The program procedures, reporting requirements, and operational procedures of the surveillance system were published in June 2004. Data collection was scheduled for January 2004. However, delays in hiring program staff and data abstractors resulted in postponement of data collection. The program coordinator was hired in October 2003 and it is anticipated that 3 birth defects investigators (BDI) will be hired by July 2004. The program coordinator and Birth Defects Advisory Board are currently developing BDI training materials. Surveillance will begin in December 2004. MCH/SSDI epidemiologists will assist the registry staff in the analysis of collected data as well as prepare reports for programmatic and policy use. Identification of Children with disabilities

and and/or CSHCN at birth will facilitate provision of information to families about services available in their community and to early intervention if appropriate.

PRAMS allows for analysis of surveys administered to recent mothers and is the first systematic and ongoing population-based perinatal surveillance system in the state. The program is implemented by the joint efforts of MCH, the Family Planning program, the State Center for Health Statistics and CDC. PRAMS allows for the study of specific risk factors affecting pregnancy and the neonate. It also provides data for needs assessments and performance measures for Title V and Title X grants, social marketing campaigns, and infant mortality review among other projects. Data collection began in 1997 with Title V and Title X funding. In 2001, CDC awarded Louisiana a PRAMS grant. Since program inception, LaPRAMS has maintained a 70% response rate meeting CDC criteria that allows state-level analysis of data. MCH epidemiologists have direct access to the PRAMS database and perform analyses and reports for dissemination.

19. 9.B Data Capacity: Adolescent Tobacco Use: The percent of adolescents in Grade 9 through 12 who reported using tobacco products in the past month

Part of the MCH SSDI coordinators scope of work is to garner information on adolescent health behavior. Information collected on this population is useful in guiding and evaluating alcohol, tobacco and drug control and prevention programs. MCH works with the Chronic Disease program that administers the Youth Tobacco Survey (YTS), to obtain information on adolescent health behavior. Currently MCH does not have direct access to the Youth Risk Behavior Survey (YRBS) conducted by the state Department of Education. Though the state participates in YRBS, the sample size is not large enough for valid statewide estimates for this age group. The YTS while it had a high response rate for 6th to 8th graders, had too low of a response rate from 9th to 12th graders to yield valid statewide estimates.

The Adolescent Health Initiative (AHI) collaborates with the DHH's Office of Addictive Disorders (OAD), to obtain information on adolescent alcohol, tobacco and drug use from the Communities that Care (CTC) survey. The study attempts to determine protective and risk factors for addictive behaviors. The survey was administered between November 1998 and January 1999, to 6th, 8th, 10th and 12th graders, and had a 76% response rate from 64 of 66 school districts statewide. Following assessment for validity 70.8% of the students in the aforementioned grades, enrolled in the study, were actually included in the analysis. Subsequent surveys were administered in the spring of 2001 and fall of 2002. Completion rates were 58.6% and 63.9% respectively. Following the development of a risk and protective factor "profile" for Louisiana youth, calculated by averaging the value of each risk and protective factors scale across all students, the state results were compared to those of the nation.

19. 9.C Data Capacity: Overweight/Obesity: The ability of the state to determine the percent of children who are obese or overweight

This is an established indicator that measures the number of children aged 2- 5 years of age with a "Body Mass Index for Age" greater than or equal to the 95th percentile, as a proportion of all children aged 2- 5 years enrolled in Women, Infants and Children (WIC) clinics. The data is collected within the Pediatric Nutrition Surveillance System (PEDNSS, established and supported by the Centers for Disease Control and Prevention (CDC)). The data are collected statewide in a computerized WIC database system found within all WIC clinics and sent for analysis to the CDC. This process can take up to six weeks, as data quality is assessed and improved. Analysis may take at least 4 weeks, as state and national measures are generated to allow for comparisons. Not all states participate in PEDNSS therefore national measures are undercounted.

CSHS has initiated a data item to collect height and weight information on all CSHCN who attended CSHS clinics. This will allow for analysis of overweight/obesity status for CSHCN.

Physical activity and other preventive programs can then be designed, implemented and individualized for this population.//2005//

IV. PRIORITIES, PERFORMANCE AND PROGRAM ACTIVITIES

A. BACKGROUND AND OVERVIEW

/2005/Louisiana, like most of the Southeastern states, differs from the rest of the Nation in terms of its demographic profile and socioeconomic status. Louisiana's African-American births comprise 41% of the total births compared with 15% nationally. Because of this, the higher low and very low birth weight rates of black infants have a disproportionate effect on our infant mortality rate. Louisiana has one of the Nation's highest overall poverty rates and ranks 48th for child poverty. It ranks 49th for the rate of families headed by a single parent. It is a predominantly rural state with a low per capita income and also low literacy levels in the general population. These factors coupled with budget shortages experienced by the State present challenges to the Title V Program in achieving the goals of decreasing mortality and morbidity in the MCH population and assuring access to needed services.

Impact on improvements in the Outcome Measures of Infant, Neonatal, Post-neonatal, Perinatal, and Child Mortality rates cannot be achieved by one or just a few activities since there are a multitude of factors that are involved with deaths in each of the periods. Likewise, the Outcome measure related to disparity in Infant Mortality for black and white infants is related to the physical health factors playing a role in infant deaths as well as issues unique to social, economic, and environmental factors and accessibility issues for the black population. The National and State Performance Measures highlight areas in which progress needs to be made in order to achieve success as measured by the Outcome Measures.

Prior to 2001, Louisiana has had an overall downward trend in our infant, neonatal, post-neonatal, perinatal, and child mortality rates. However the data from 2001 and 2002 as well as an overall trend analysis indicate increases in these rates. The factors associated with these increases have been looked at in the maternal and infant demographic, medical, and geographic arenas. One area of note that was found in the analysis was an underreporting of deaths in infants weighing less than 500 grams at birth leading to false lowering of the infant mortality rate in previous years. Improvements in the vital records system with increased reporting of deaths of these infants is one factor associated with the increase in the infant mortality rate. Improvements in the birth weight specific mortality rates for infants weighing more than 1000 grams were off set by increased mortality rates for the smallest of infant weighing less than 1000 grams. This emphasizes the need to improve efforts for the prevention of prematurity and low birth weight.

In the past year, progress has been made in the National and State Performance Measures. We have improved in the percentage of infants who received state-mandated neonatal screening (NPM #1), our immunization rates for children (NPM#7), the motor vehicle crash deaths for children 14 years and younger (NPM#10), the percentage of newborns screened for hearing before hospital discharge (NPM #12), the percent of uninsured children (NPM#13), the percentage of potentially Medicaid eligible children who received a service paid by the Medicaid Program (NPM#14) the teen suicide deaths rate (NPM#16), and the percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates (NPM#17. There were slight improvements in the Performance Measures for our teen pregnancy rates (NPM#8), the percent of very low birth weight infants (NPM#15), and the percent of infants born to pregnant women receiving prenatal care beginning in the first trimester (NPM#18). There was no additional data to change in the National Performance Measures related to Children with Special Health Care Needs (NPM#2 - 6) or the percent of third grade children who receive protective sealants (NPM #9).

The State Performance Measures that showed improvement are the percent of all children and adolescents that have access to school-based health center services (SPM#1), the percent of CSHS patients with case management (SPM#4), the epidemiology capacity (SPM#9) and the percent of licensed day care centers with a health consultant contact (SPM#10). Measures that showed slight improvements were the percent of women in need of family planning services

who received such services (SPM#2) and the rate of children under 18 who have been abused or neglected (SPM# 3). There was no additional data to change the percent of women who have had a baby reporting physical abuse (SPM#6) and the percent of women who use substances during pregnancy (SPM#7). The Measure that showed a worsening trend was the percent of children age 2 - 5 on WIC greater than or equal to the 95th percentile for BMI for age (SPM#5). The SPM related to percent of infant deaths due to SIDS that have a compete autopsy and death scene investigation (SPM#8) was replaced by the more direct measure of the SIDS death rate (SPM#11).

The annual assessment of the progress on the National and State Performance Measures provide reassurance in some areas that progress is being made and at the same time points out specific areas that efforts need to be addressed or intensified to make improvements. Nonetheless, we still feel confident that the priority needs that were developed in our 2000 Needs Assessment and the approach we have initiated to address those needs will have the positive outcomes we seek and ultimately will improve the National Outcome Measures. //2005//

B. STATE PRIORITIES

/2005/Priority Need 1: Decrease infant mortality and morbidity, preterm births and low birth weight. Related Performance Measures: National Performance Measures (NPM) 1, 8, 15, 17, 18 and State Performance Measures (SPM) 6, 7, 11 (formerly 8)

OPH operates 70 parish health units, located in 62 of Louisiana's 64 parishes, through which the MCH Program provides a safety net of health care for uninsured women and infants, and those with Medicaid coverage who have limited access to private providers. MCH funds community-based outreach, case management and home visiting programs for pregnant women and infants. A contract with the Medical Center of Louisiana in New Orleans addresses substance abuse for pregnant women and the Office of Addictive Disorders provides a substance abuse counselor to provide services in an MCH funded prenatal clinic in Monroe. MCH targets smoking cessation services for perinatal populations through a contract with the American Cancer Society. MCH administers public information and media campaigns to reduce infant mortality promoting early prenatal care and healthy behaviors, SIDS risk reduction, and child abuse prevention. MCH assists parish and regional MCH and public health leaders to address the problem of infant mortality through data analysis, technical assistance and funding of interventions. Areas with high infant mortality rates are targeted, while the remaining areas are assessed to assure that the infrastructure and capacity is in place to care for high-risk pregnant women and those with access problems. In order to gather more detailed information on perinatal deaths, OPH has initiated the development of regional Feto-Infant Mortality Reviews (FIMR) in all regions of the state. In addition, data collection on birth defects, set to begin in 2004, will help improve birth outcomes.

Priority Need 2: Decrease mortality and morbidity among adolescents. Related Performance Measures: NPM 13, 16, SPM 1

The Adolescent School Health Initiative Program funds and provides technical assistance to 51 School Based Health Centers to provide primary and preventive physical and mental health services, which includes medical and psychosocial history; physical examination; risk assessment; dental assessment; hearing and vision screening; immunizations; assessment of educational achievement and attendance problems; treatment of minor and acute problems; management of chronic problems; dispensing medications; referral for STD management; HIV testing and counseling; counseling and referral for physical and sexual abuse; conflict resolution/anger management skills; social service assessment; and health education. The OPH Family Planning Program receives supplemental funding from Title V and provides comprehensive medical, educational, nutritional, psychosocial and family planning services to adolescents. One fourth of the patients served by the Family Planning Program are under age

20. The CSHS Program provides subspecialty care for adolescents with special health care needs. Adolescents comprise approximately half of the CSHS population. Transition issues focus on self-determination and navigating the adult health care system. MCH funds the Louisiana Adolescent Suicide Prevention Task Force to develop the statewide plan on adolescent suicide prevention and implement training to school personnel on suicide prevention.

Priority Need 3: Decrease intentional and unintentional injury in the MCH and CSHCN populations. Related Performance Measures: NPM 10, 16, SPM 3, 6

The MCH funds Louisiana's SAFE KIDS program, a comprehensive injury prevention program that organizes local chapters throughout the state, distributes newsletters and pamphlets, conducts special events, and participates in health fairs. Interventions address car, gun and fire safety, childproofing homes, bicycle helmet use, and sports injury prevention. MCH has established Regional MCH Injury Prevention Coordinators who work to decrease unintentional injuries in children in each of the 9 regions. MCH funds a child abuse prevention information campaign in conjunction with Prevent Child Abuse Louisiana, the State chapter of Prevent Child Abuse America. Radio commercials, billboards, and a speaker's bureau promote healthy parenting, positive discipline and the toll free counseling hotline for parents. The Prevent Abuse and Neglect through Dental Awareness program distributes materials on recognizing and reporting signs of child abuse and neglect to all dentists and hygienists in the state. The Child Death Review Panel, established by the State Legislature in 1993, reviews all unexpected deaths in children under the age of 15. The MCH Program currently staffs a full time position for the Child Death Review Panel. CSHS provided leadership and funding for a special project to address prevention of secondary disabilities in CSHCN from birth to age 5.

Priority Need 4: Increase care coordination among children with special health care needs. Related Performance Measures: NPM 3, 5, 6, SPM 4

The CSHS Program implements a formalized care coordination model which includes medical home coordination as an integral component of the plan of care and promotion of health strategies that includes primary, secondary and tertiary prevention of disabilities. The CSHS Care Coordination Program provides developmentally appropriate counseling according to the child's age and state of growth and development. Parent participation in the program assures that the CSHS Program is family-centered and advocacy-focused. CSHS has had parent participation for over 14 years. Parent Liaisons attend CSHS clinics to offer emotional support and resources to families of CSHCN. Parent input into program policy and procedures occurs with three statewide parent coordinators who have collaborated with staff in the development of the Care Coordination model, continuous Quality Improvement, Universal Newborn Hearing Screening Systems, and the Medical Home project. The Part C program, Early Steps, also provides Family Service coordination for eligible children from birth to age 3.

Priority Need 5: Increase access to and utilization of comprehensive primary, preventive and specialty care services for women of reproductive age, infants, children, adolescents and children with special health care needs with particular emphasis on transportation and provider availability. Related Performance Measures: NPM 3, 4, 5, 7, 13, 14, SPM 1, 2, 4

MCH provides comprehensive health services to women of reproductive age, infants, children, and CSHCN who lack access to services due to financial or other barriers including the lack of providers. These services are provided through the statewide network of parish health units, community health centers, and other contract agencies. Children's Special Health Care Services provides subspecialty health care and care coordination services in nine regional subspecialty clinics. The CSHS clinics bring subspecialty providers to the rural areas of the state where these services are not available. MCH initiates services in areas of the state with access problems. Outreach workers are employed in high-risk areas of the state to assist patients overcome barriers to care. The CSHS Medical Home project specifically targets

access and utilization of primary care by families of CSHCN.

Priority Need 6: Assure that all children, especially those with special health care needs, have a medical home for comprehensive primary and preventive health care, with coordination of all health and support services. Related Performance Measures: NPM 3, 4, 5, 6, 13, 14, SPM 4

The Community Care Program provides physician primary care case management for Medicaid clients. All children in CSHS medical clinics are screened for primary health care coverage, and families are referred to primary care providers when the child has none. CSHS care coordination includes medical home coordination as an integral component of the plan of care, and program staff will work with families and primary care physicians to make a medical home a reality for children and families. The CSHS Program has taken a leadership role in the Medical Home Project for Louisiana.

Priority Need 7: Assure the oral health needs of the MCH and CSHCN populations are met. Related Performance Measure: NPM 9

CSHS funds a Dental Clinic for CSHCN in the New Orleans area. Services are provided by LSU School of Dentistry (LSUSD) and are specially designed to be readily accessible to this population, known to have barriers to accessing regular dental care. This project also enhances training for Dental School students in providing care to CSHCN. CSHS provides assistance through DHH/OPH Regional Offices for non-Medicaid eligible children to receive routine dental services through the private sector. The Oral Health Program (OHP), in conjunction with the Fluoridation Advisory Board of Louisiana, work with non-fluoridated communities. The OHP provides funding and technical assistance for the fluoridation projects. The OHP assesses the oral health needs of children and adolescents in the state. The surveillance of 3rd grade school children is conducted every 5 years with participation of school nurses to assess the oral health of these children, providing information on untreated caries, sealant prevalence, and the urgency for treatment.

Priority Need 8: Address the social, emotional, and psychological needs of the MCH and CSHCN populations. Related Performance Measures: SPM 1, 3, 4, 6

Prenatal care services are directed at assuring maternal and fetal optimal health, healthy behaviors, minimization of risk factors and early recognition, treatment and referral of problems that may put mothers and infants at risk of morbidity directly related to infant mortality. MCH funds the Nurse-Family Partnership (NFP) Program, a program for first time mothers of low socioeconomic status, in seven regions of the State. MCH collaborates with the Office of Mental Health (OMH) to provide mental health support and services to the Program. OMH assigns mental health workers to the NFP team. The CSHS Program provides parent support through all clinic team members. Parent Liaisons organize and participate in support groups for families of CSHCN. CSHS, through the Early Steps program, has begun a collaboration with the Early Childhood Supports and Services program of the OMH. This project provides mental health services to children from birth to age 5.

MCH is developing a new parenting newsletter series to mail to Louisiana parents. The series emphasizes developing healthy infant caregiver relationships, healthy social and emotional development, parent and parenting issues, and mental health concerns including maternal depression and family stress. MCH funds the implementation of an infant mental health program housed in a public health clinic in New Orleans. A 30 hour Infant Mental Health Educational Series was developed by an Infant Mental Health Specialist in MCH. The series emphasizes attachment theory and current knowledge of infant social and emotional development. This Infant Mental Health Training is provided to public health staff, including CSHS staff, across the state. MCH has hired a Mental Health Coordinator who will assure that social-emotional health is part of all MCH interventions. A psychosocial risk assessment for infants and pregnant women is being implemented along with protocols for referral and

treatment.

Priority Need 9: Assure early identification and referral of substance abuse, domestic violence and child abuse and neglect. Related Performance Measures: SPM 1, 3, 4, 6, 7

A risk assessment is conducted on all patients receiving comprehensive prenatal care in the parish health units, and includes questions about substance abuse and domestic violence. Referrals are made to local substance abuse treatment facilities and battered women shelters. A Prenatal Risk Assessment tool focusing on psychosocial risk factors, specifically substance use, domestic violence, financial/social service needs and mental health is being disseminated for use along with training for brief intervention. The MCH child health record is used to identify infants and children at risk for child abuse and neglect by looking at factors that have been associated with child abuse and neglect, such as maternal age, previous history of child abuse, the parent being abused as a child, domestic violence and substance use and abuse. MCH utilizes public health nurses to assist child protection workers in investigating suspected cases of medical neglect, malnutrition and failure through an interagency agreement with Office of Community Services. MCH funds four paraprofessional home visiting programs in four parishes. These programs seek to prevent child abuse and neglect by focusing interventions on promoting healthy pregnancies and child growth and development, modeling and fostering positive parenting skills and parent-child interactions, assuring provision of needed health care, and developing support systems for families. CSHS, through Early Steps, has entered into an agreement with the Office of Community Services to provide for a mandatory referral of all children, birth to age 3, with substantiated abuse or neglect findings to the Part C System.

Priority Need 10: Promote healthy and reduce risk taking behaviors of adolescents, pregnant women and parents through public, professional and patient education. Related Performance Measures: NPM 8, 10, 16, SPM 1, 3, 7, 10, 11 (formerly 8)

Parish health units provide all women seeking prenatal care receive extensive counseling and education on prenatal risks and how to keep healthy. Topics include substance abuse, nutrition, exercise, signs of early labor, prevention of sexually transmitted diseases, breastfeeding and others. Pamphlets and videos are additional methods used in patient education. The Oral Health Program provides information to pregnant women through the WIC Program and the parish health units on the effects of periodontal disease and the possible consequences of pre-term delivery. Families of children receiving preventive services at the health unit are screened for environmental factors related to safety, injury prevention and lead poisoning. Material on injury prevention, lead poisoning prevention, and SIDS risk reduction are provided to families.

Partners for Healthy Babies, a social marketing campaign, uses communication and education strategies to reach both the MCH public and professionals concerning prenatal health. Communication is population-based and includes multi-media presentation and direct presentations (speeches, health fairs). A clearinghouse of resources and materials including audiovisuals and print material on perinatal substance abuse is maintained by MCH. These are made available and distributed to public and private providers, community organizations and individuals. OPH and Office of Addictive Disorders have an interagency agreement to jointly provide pregnancy testing in the OAD treatment facilities statewide.

MCH educates women in New Orleans about AZT therapy for HIV-infected pregnant women and the importance of knowing one's HIV status through a contract with Family, Advocacy, Care and Education Services. Education materials are distributed via provider offices, community events and peer education. SIDS risk reduction awareness and public education is implemented within high-risk target population areas of the state through the development of a social marketing public information campaign about safe sleep environment. The SIDS program's educational efforts target social workers, emergency medical staff, police officers

and medical examiners statewide. The MCH Obesity Committee works on policies promoting and supporting healthy eating, physical activity and healthy weight among children. The MCH Program continues to expand its existing Child Care Health Consultant Initiative. Approximately 160 Child Care Health Consultants provide technical assistance, act as health resource and referral persons, and provide access to health care information. CSHS staff provides training to childcare centers in relation to CSHCN to increase access and improve services to children with disabilities who are enrolled in day care centers and Head Start.//2005//

C. NATIONAL PERFORMANCE MEASURES

Performance Measure 01: *The percent of newborns who are screened and confirmed with condition(s) mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) who receive appropriate follow up as defined by their State.*

a. Last Year's Accomplishments

Louisiana's newborn screening program screens for the following 5 conditions: phenylketonuria (PKU), congenital hypothyroidism, sickle cell disease, biotinidase deficiency, and galactosemia. The Genetics staff provide timely follow-up on all positive screens to ensure early diagnosis and treatment. Long term tracking and follow-up is provided for metabolic and sickle cell patients. Follow-up for congenital hypothyroidism patients ends at the point of verification of treatment.

The Genetics Section ensures that greater than 95% of newborns are screened for all the diseases on the official battery by providing education to medical providers on the legislation and rule mandating screening, and by only allowing OPH approved laboratories to perform the battery of tests on Louisiana newborns. Progress was made on the plan to match newborn screening result records to birth records through rule amendment and meetings with staff from Genetics, Vital Records, MCH Epidemiology and the State Central Laboratory.

Of approximately 65,249 newborns screened, there were 3 detected with classical PKU, 41 with congenital hypothyroidism, 79 with sickle cell disease, 3 with biotinidase and none with galactosemia. All newborns detected were followed up and on treatment within proper timelines except for 6 patients (7.5%) with sickle cell disease.

Direct Services
Genetics continued to contract with medical geneticists to conduct regional genetics clinics at 10 sites reaching 500 families. Direct services to parents and guardians of newborns with positive screening results were provided to ensure early detection and initiation into specialized care.

Enabling Services
Contracts were continued with Sickle Cell Foundations in 7 regions of the state to provide the clinic based wrap around services as well as home visiting to reinforce good sickle cell care.

Population-Based Services
Universal screening for galactosemia became completely statewide on August 20, 2003 when the private hospital lab delayed in adopting this screening began screening all their newborns by using the enzyme method. The Louisiana Newborn Screening Advisory Committee (LNSAC) continued to meet on the expansion of screening through tandem mass spectrometry and improving the policy for repeat screening of transfused newborns.

Infrastructure Building Services
An amendment to the newborn screening rule (LAC 48:6300) was promulgated and published as a rule in the Louisiana Register of August 20, 2003. This rule improves the screening and

follow-up system by 1) adds galactosemia to the panel; 2) adds reporting and surveillance requirements for galactosemia for private labs; Progress continued on the matching of the newborn screening lab data with vital records birth records data to determine the percentage of newborns receiving an initial screen. The LNSAC continued to meet with an expanded membership representing endocrinology, hematology, pediatrics and various patient advocacy groups.

b. Current Activities

Direct Services and Enabling Services
Genetics continues to conduct regional genetics clinics for evaluation and for the referral of metabolic patients identified through newborn screening. Contracts are continued for regional sickle cell foundations.

Population-Based Services
Genetics continues to collaborate with the State Central Laboratory on the operation of a newborn screening and follow-up system to include universal testing with a panel of five (5) diseases. Planning continues for the adoption of screening by tandem mass spectrometry along with the development of the other four components of the system to include follow-up, diagnosis, management and evaluation. An ad hoc committee to the LNSAC selected a priority list of 5 diseases to detect when tandem mass spectrometry is adopted. These diseases are the following: Homocystinuria, Maple Syrup Urine Disease (MSUD), Medium Chain Acyl-CoA Dehydrogenase Deficiency (MCAD), Citrullinemia and Argininosuccinic Aciduria (ASA).

Infrastructure Building Services
Genetics has met a number of times with the Tulane Human Genetics Program to assist on development of a HRSA-04-055 Genetic Services Project. The LNSAC will continue to meet. The Louisiana Sickle Cell Medical Council will also meet to develop a plan for transitional and adult care, and to address improvements in the current regional pediatric sickle cell system. Surveillance reporting of newborn screening data by the two private labs started in the spring of 2004.

c. Plan for the Coming Year

Objective: Increase to 95% the percent of infants who are screened and receive appropriate follow-up and referral.

Direct and Enabling Services
The Genetics Section will continue to ensure the provision of specialized medical and nutritional management for 100% of affected infants identified through newborn screening pursuant to the adoption of tandem mass spectrometry. This will involve contracts with medical schools to include this new patient population.

Population-Based Services
The Genetics Section plans to adopt tandem mass spectrometry to the official newborn screening battery by the end of the year, which will in turn involve expansions in every component of the newborn screening system. An upgrade of the tracking and follow-up software system and an addition of one full time registered dietitian are planned to partially meet the demands of expanded screening.

Infrastructure Building Services
The Genetics Section will continue to convene the Newborn Screening Advisory Committee to address the planned expansion using tandem mass spectrometry and screening for congenital adrenal hyperplasia. Increasing the availability of screening result data of patients for authorized medical providers will be evaluated and considered, such as inclusion of newborn

screening specific data fields on the Immunization's LINK System. Consideration will continue for consolidating the newborn hearing infrastructure with that of the newborn heel stick system.

The following objectives are planned for the purpose of improving both professional and parent/patient knowledge level:
1. Improve the medical community's knowledge level and understanding about expanded screening, screening protocols for transfused infants, and skill in blood specimen collection.
2. Provide CE offerings to high-risk maternity staff and to adolescent PKU girls on fetal effects of maternal PKU and to general medical providers on sickle cell services and care.

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

a. Last Year's Accomplishments

Since 1992 Children's Special Health Services (CSHS) has provided Parent Liaisons (PL) through the non-profit organization Families Helping Families. The PLs are located in the 9 regional clinics across the state. PLs provide direct consultation and support to families, enabling them to make informed decisions concerning their children's care and treatment. SLAITS data for 2002 indicated that 55.2% of families of children 0-18 with special health care needs in Louisiana reported that they partner in decision- making at all levels and are satisfied with the services they receive. The annual performance objective was 60%.

Direct and Enabling Services
CSHS provided paid PLs in every regional CSHS clinic. They were trained to offer support and referrals to other agencies to ensure that the families are getting the services that they need. All PLs were parents of a child with a special health care need. Therefore, they were able to relate and offer support to the parents at the clinics. The PLs in the 9 regional CSHS clinics were trained to hold workshops and support groups for the families that attended the clinics. The PLs were also trained to provide outreach to the community on issues relating to children with special health care needs, as well as to work as a team with the staff at the CSHS clinics. In this way, the PLs are able to share information with the staff and determine where particular needs exist for parents. The support provided by PLs enabled families to be active partners in decision-making at all levels.

Population Based Services
CSHS facilitated family education by inviting the families to attend workshops and trainings. Parents were invited to participate as speakers and CSHS advocated for parents to be represented in other agency decision-making process and supports. CSHS also hired Community Outreach Specialists for Early Steps Louisiana's early intervention program. The Community Outreach Specialists were Parents of young children who have a disability and have received services through the Part C Office of Special Education System in the past.

Infrastructure Building Services
CSHS employed several paid parent consultants to assist with bridging the gap between the program and families and to assist with representation of family views in policy making. CSHS had a Statewide Parent Consultant that coordinated services for the PLs in all OPH sites. CSHS also employed a Parent Training Consultant. This person provided training for all of the CSHS PLs, as well as held many community based programs for families.
CSHS facilitated family participation in numerous trainings by providing stipends to families to enable them participate. The PL contracts also included funds that allowed them to attend the Parent to Parent conference biannually.
In addition, CSHS employed a Statewide Parent Coordinator for the Hearing, Speech and

Vision program. Each of the paid parent positions provided input into CSHS management and policy decisions.

b. Current Activities

Direct and Enabling Services
CSHS continues to empower families served in the nine regions by offering Parent Liaison support to families. By providing direct consultation with families, CSHS strived to ensure that families were informed about services and on how to be active participants in all decisions about their child's services.

Population Based Services
CSHS collaborated with families and community partners to present several programs that assisted families to be active partners in decision-making for their children and in being better consumers about services for their children. The Parent Liaisons assisted with the Medical Home training programs in Houma in October 2003 and Monroe in April 2003. Parent Liaisons also presented statewide workshops on such topics as seizures, autism and disability rights.

Infrastructure Building Services
CSHS continues to provide stipends for families to attend trainings throughout the state. CSHS also continues to provide funding for the Parent Liaisons in all the nine regions to work with families in a clinical setting.

c. Plan for the Coming Year

Objective: To increase to 62% the percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive.

Direct and Enabling Services
CSHS will continue to employ Parent Liaisons to work with families in the clinical setting. CSHS will also continue to offer trainings to the regional Parent Liaisons to enhance their skills in providing services to families, as well as how to teach parents to navigate the complex health care systems and evaluate quality services for their children.

Population Based Services
CSHS will continue to provide trainings for families to assist them in being active partners in decision making for their children. CSHS will also continue to facilitate Medical Home trainings statewide.

Infrastructure Building
CSHS will continue to partner at the statewide and local levels to facilitate inclusion of parents in decision making for their children with special health care needs. CSHS will also continue to employ paid parent consultants at both the state and local levels and include them in programmatic policy making. CSHS will utilize parent consultants and parents of children enrolled in the program to evaluate the results of the needs assessment and in developing long-range plans for the program.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

a. Last Year's Accomplishments

SLAITS data for 2002 indicated that 48.8% of children with special health care needs in

Louisiana received coordinated, ongoing comprehensive care within a MH. The annual performance objective was 55%.

Direct and Enabling Services
CSHS care coordination services has included ongoing screening of all children for accessibility and utilization of "Medical Home" services. Families without primary heath care coverage were referred or informed of where services are available. Staff also assured that children with Medicaid coverage were linked to a primary care provider. The state Medicaid program instituted a Community Care program, which is a comprehensive health delivery system, providing education, preventive care, acute care and referrals to specialists.

Population-Based Services
CSHS provided leadership in the state in informing and educating professionals, families and child advocates about the MH model of health care delivery through development of "Medical Home" training and education programs. Each region of the state developed a plan to inform and educate families and professionals on the MH concept. Since Spring 2003, CSHS has participated in the Medical Home Learning Collaborative national training sessions. These sessions have enabled 3 practices to initiate and improve all components of a MH within their practices.

Infrastructure Building Services
CSHS and Family Voices was granted a Medical Home Learning Collaborative grant in December 2002, which provided training and support to OPH staff and pediatric primary health care practices in the state to set up "model" MH practices. Three physician practices were selected to participate in this program and completed the first training session in Miami in April 2003. Two practices have assembled a MH team that consists of family members, AAP partners, Community Care partners, as well as others to participate in the development of the MH practice. OPH will provide funding for each of the practices in the collaborative to hire a Care Coordinator to facilitate the coordination of children with special health care needs in each practice.

CSHS also dedicated funds to facilitate a coordinated system to promote the "Medical Home" concept for CSHCN statewide. Nine regional OPH medical home leadership teams were assembled in spring 2002 to plan and promote the MH concept, in partnership with their local health care community providers and families. Tentative dates were set for all OPH sites to present a MH training, with trainings presented in Houma in October 2003 and Monroe in April 2003.

CSHS has contracted with Louisiana State University Health Sciences Center to perform a Long Range Plan Needs Assessment to determine the resources/capacity of each area of the state, including private providers willing to provide MH services for CSHCN.

b. Current Activities

Direct and Enabling Services
In CSHS clinics, staff continues to screen and refer all children for primary health care coverage at each clinic visit and will continue to assist families to locate and access these services. CSHS has also instituted a transition program for all children age 14 who attend CSHS clinics. One component of this system is to assist adolescents and their families in locating and establishing an ongoing, comprehensive relationship with a medical home provider. In addition, the transition program seeks to educate and inform families of the mechanisms to begin the transition to adult health care providers.

Population-Based Services
CSHS has established partnerships with three pediatric practices through the Medical Home

Initiative grant. These practices are identifying children with special health care needs within the practice and providing additional services, such as care coordination and linkages to community providers. In addition, parent meetings are held during clinic hours at one of the sites to involve parents and inform them of the Medical Home concept. The CSHS Medical Home effort has progressed from a single committee to a comprehensive team approach. CSHS is working closely with regional teams to look at strategies to educate and inform health care providers and families on the AAP recommendations for "Medical Home."

Infrastructure Building Services
CSHS continues to survey health care providers statewide through the Long Range Plan Needs Assessment. Results from this study will provide information about the availability of medical home providers statewide, particularly for children with special health care needs.

c. Plan for the Coming Year

Objective: To increase to 55% the percent of children with special health care needs, age 0 to 18, who receive coordinated, ongoing, comprehensive care within a medical home.

Direct and Enabling Services
CSHS will continue to screen all children receiving direct health care services for primary health care coverage and will continue to assist families in accessing these services. CSHS will also continue to work with Medicaid and local health care providers to facilitate the accessibility of preventative and comprehensive health care services for children with special health care needs. CSHS will expand transition services in 2005 to serve children ages 14 & 15. A component of the transition services assists adolescents and their families in locating and utilizing medical home services.

Population-Based Services
CSHS will continue to provide funding to assist three private practices to develop model medical home practices that can be resources to other providers. CSHS will increase capacity for a medical home for all children with a special health care need in Louisiana through its leadership and participation in the Medical Home project and the Medical Home Learning Collaborative.

Infrastructure Building Services
With ongoing support from the National Initiative for Children's Healthcare Quality (NICHQ), CSHS will continue to convene regional teams to implement Medical Home statewide. This will be accomplished by bringing families, young adults, OPH administrative staff and private health care providers from across the state to plan and implement medical home programs and systems.
CSHS will begin to analyze preliminary data from the Long Range Plan Needs Assessment to develop information systems regarding the availability of medical home providers statewide.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

a. Last Year's Accomplishments

According to the 2002 SLAITS data, only 51.9% of families in Louisiana having children with special health care needs report having adequate insurance coverage to meet their needs. Much of Louisiana is extremely rural and there is a large portion of the general population who are uninsured. These families receive medical care either through the state's 10 public hospitals or in the emergency room of their local hospital?thus, placing a large burden on the

state's few resources. LaCHIP (SCHIP) funds have been available to Louisiana citizens since 1998. However, many families are not eligible because they are insured by some other means (albeit sometimes inadequate) or they fail to meet the income eligibility criteria (although the household income is not sufficient to meet their healthcare needs). Of those families who do have private insurance, many have plans that only provide rudimentary coverage and do not provide for the extraordinary needs of children with chronic health conditions. The annual performance objective was 55%. CSHS will utilize future National CSHCN surveys to continue to measure progress in this area.

Direct Services
Clinic staff in each of the state's nine regions were asked to screen all children during regular clinic visits for insurance coverage, and make referrals as needed. For those families who did have coverage, information concerning coverage was checked for accuracy, and updated if needed. Families were counseled concerning eligibility requirements and referral procedures, and were given assistance in the completion of forms. Staff also assisted patients who had private insurance with various issues pertaining to their individual policies. Enrollment in Medicaid or LaChip is a mandatory requirement for participation in CSHS for families that meet Medicaid eligibility requirements.

Enabling Services
Brochures outlining the services of the Social Security Administration, LaCHIP, etc. were available in all CSHS clinic-waiting areas. Staff was available to answer questions as needed.

Population-Based Services
In addition to assisting CSHS patients with referrals for programs, which they might qualify, CSHS staff was also instrumental in providing physicians and allied health professionals with necessary information regarding policies and procedures of patients' various insurance policies so that payment could be obtained.

Infrastructure Building Services
In an effort to meet the needs of CSHS patients, staff worked to build relationships with various insurance entities that cover patients and their families. This often entailed working with companies to assure that needed services were adequately covered. CSHS provided contact information to the Louisiana KidMed (EPSDT) referral system so that the availability of specialized pediatric care would be known and utilized.

b. Current Activities

Direct Services
CSHS staff continued to screen and update insurance information for all patients during clinic visits. If families were uninsured, appropriate referrals were made. Any issues pertaining to private insurance or state/federal funding sources were dealt with on as as-needed basis.

Enabling Services
Brochures for various public programs continue to be available in all clinic waiting areas. Staff work to assist patients and assure that families have a clear understanding of their particular insurance carrier?whether private insurance or from a public funding source. In addition, CSHS facilitated a combination application form for children referred to the Part C System, EarlySteps. The EarlySteps application also serves as an application for Medicaid, CSHS and for services with the Office of Citizens with Developmental Disabilities.

Population Based Services
Staff continues to work with CSHS patients and their insurance carriers to ensure that all necessary services are adequately covered. In addition, staff continues to work with physicians and other providers to supply sufficient information to insurance providers so that needed are

received without delay.

Infrastructure Building Services
Staff continued to work to build relationships with Louisiana's public and private insurance agencies to assist patients to get their needs met. CSHS will also continue to work with Medicaid to bring to their attention issues related to CSHCN and to facilitate seamless systems of service delivery.

c. Plan for the Coming Year

Objective: To increase to 59% the number of children with special health care needs, ages 0-18, who have either public or private insurance that is adequate to meet their needs.

Direct Services
During the upcoming year, staff will continue to work to link CSHS patients and their families with agencies that provide insurance coverage, as appropriate.

Enabling Services
CSHS will continue to provide informational brochures for families. Staff will also continue to assist, as needed, with the completion of forms. CSHS will also continue to work with the Part C System to utilize a combination application form for children referred to EarlySteps. The EarlySteps application will continue to serve as an application for Medicaid, CSHS and for services with the Office of Citizens with Developmental Disabilities.

Population Based Services
During the upcoming year, CSHS staff will work to increase awareness of state and federal programs that serve families of children with special health care needs. Clinic social workers will meet with families during clinics visits to assess their needs and make referrals, as needed. Social workers will also discuss any insurance issues with the physician and the rest of the multidisciplinary team to assure that appropriate forms are completed and that staff communicates with the insurance company, as needed, so that services can be delivered in a timely fashion.

Infrastructure Building Services
CSHS will continue to partner with Medicaid to assure that appropriate children are enrolled. Medicaid will continue to be invited to have exhibits at future CSHS trainings to distribute informational brochures. CSHS will continue to work with Medicaid and private insurance companies so that all prescriptions and necessary paperwork are submitted so that the patient receives medication, durable medical equipment, etc. in a timely manner.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

a. Last Year's Accomplishments

Children's Special Health Services (CSHS) provided accessible services in all nine regions of the state for families of children with special health care needs, with emphasis on linking families to community based services. SLAITS data for 2002 indicated that 68.6% of families in Louisiana reported that community based services were organized so that they could use them. The annual performance objective was 70%. CSHS will utilize future National CSHCN surveys to measure progress of this objective.

Direct and Enabling Services

CSHS staff provided direct information and referral to families attending clinics statewide. CSHS Parent Liaison staff also presented workshops and trainings for families on a wide variety of topics including community services, parenting skills, knowing your rights, and how to trainings.

Population Based Services
CSHS Parent Liaisons provided trainings to families statewide regarding community-based services. In addition, Parent Liaisons, in conjunction with Families Helping Families, were able to link families to needed resources through their large up to date referral system. CSHS also publishes a newsletter that is sent to families receiving services in CSHS, as well as families on the Families Helping Families database. This newsletter includes community and statewide events, as well as updates on community and state services that may affect children with special health care needs.

Infrastructure Building Services
CSHS provided paid parent consultants, Parent Liaisons, in all 9 OPH regions of the state. These parents provided direct consultation to families in CSHS clinics, as well as community-based trainings statewide. Parent Liaisons are trained about different agencies in our state, including but not limited to CSHS. With the redesign of the EarlySteps system of early intervention services (Part C of IDEA) under CSHS, collaboration with Medicaid, the Office for Citizens with Developmental Disabilities (OCDD), the Office of Mental Health and the Office of Family Support has been implemented. A single intake form has been adopted for use in EarlySteps, OCDD and Medicaid. This has resulted in easier intake and referrals between these three agencies for families.

b. Current Activities

Direct and Enabling Services
CSHS has continued to offer support systems for families in the clinic setting, with emphasis on linking families to community resources. CSHS has also instituted a transition program for all children age 14 who attend CSHS clinics. A component of this system is to assist adolescents and their families in locating and utilizing needed community-based services.

Population Based Services
CSHS has also continued to offer trainings to families statewide so that they can stay informed and knowledgeable about community resources and how to navigate systems to access services. CSHS has also continued to publish a newsletter to families served in CSHS and through Families Helping Families.

Infrastructure
CSHS continues to provide services to the nine regional areas of the state, making the services accessible to the families who utilize the services. CSHS has also worked closely with community agencies to develop mechanisms for sharing information and making sure that information is easily accessible for families.
CSHS and EarlySteps have continued collaboration with the Office of Mental Health and their Early Childhood Supports and Services Program to reduce duplication of effort. Stakeholders in Region IV have begun a pilot effort to combine meetings to address common issues.

c. Plan for the Coming Year

Objective: To increase to 75% the percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily.

Direct and Enabling
CSHS will continue to have Parent Liaisons in the nine regions of the state, providing direct consultation to families receiving services in the CSHS clinics. CSHS will expand transition services in 2005 to serve children ages 14 & 15. A component of the transition services addresses linking families to needed community based services. CSHS will expand care coordination by funding a care coordinator for a third pediatric practice in the medical home collaborative.

Population Based Services
CSHS will continue to train Parent Liaisons so that our families are well informed and can take advantage of the of the community based resources to assist parents in caring for their special needs children. CSHS will continue to publish a newsletter to families served in CSHS and through Families Helping Families.The Birth Defects Registry and the EarlySteps System will join with the Newborn Hearing Screening Program in early identification of children with disabilities and chronic medical conditions and facilitate referrals as early as possible to CSHS, community resources and family support.

Infrastructure Building and Services
CSHS will continue to provide services to the nine regional areas of the state, making the services accessible to the families who utilize the services. CSHS will also work closely with community agencies to develop mechanisms for sharing information and making sure that information is easily accessible for families.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life. (CSHCN Survey)*

a. Last Year's Accomplishments

In recent years a larger portion of children with special health care needs are surviving into adulthood, many of which are capable of going on to lead productive lives as adults. This has caused CSHS to make critical changes in the manner in which services are rendered to adolescents and young adults and their families. 2002 SLAITS data indicated that only 5.8% of youth in Louisiana received services necessary to make transitions into all aspects of adult life. The annual performance objective was 8%. CSHS will utilize future National CSHCN surveys to measure progress of this objective.

Direct Services
Clinic staff in each of the nine OPH regions screened adolescents and young adults during clinic visits for those services that were necessary to assist them with transitioning into adulthood. Referrals were made, as needed, for post-secondary education, vocational programs, social security/SSI, housing, transportation services, and adult medical services. Staff also provided counseling on self-determination and assisting patients in achieving the maximum level of independence possible.

Enabling Services
CSHS staff provided educational materials and brochures to adolescents and young adults and their families on the various resources available to them as they transition into adulthood. CSHS partnered with the Department of Education and Louisiana Rehabilitation Services in an effort to better provide information on transition services.

Population Based Services
CSHS staff worked to provide information and referrals to adolescents and young people and their families as they transition into the adult health care arena. CSHS has, for many years,

been a leader in encouraging families to attend workshops and participate in other ways so as to assist the families as they transition out of CSHS into adult services.

Infrastructure Building Services
In addition to assisting CSHS patients in the acquisition of age appropriate services, CSHS was instrumental in informing and educating physicians, allied health professionals, and others about the health care needs of adolescents and young adults in transition. Training on transition issues was incorporated into several Medical Home Training sessions throughout the state. A panel of young adults provided information to professionals. CSHS staff provided information on self-determination and assisting young adults to become more independent. Also, in May 2003, CSHS contracted with Louisiana State University to perform a Long Range Plan Needs Assessment to assist with program planning. Components of this plan will focus on availability of health care for young adults with special health care needs.

b. Current Activities

Direct Services
CSHS staff continues to screen patients seen in clinics and provide necessary referral information for adolescents and young adults on transition services. CSHS staff began a formal transition process for staff to use with all adolescent/young adults patients beginning at age 14. Patients will have an initial screening, which will be updated annually. This is a "phase in" system. During the upcoming year, staff will begin to screen all 14 -- 15 year old patients. Additional age groups will be added on a regular basis.

Enabling Services
CSHS staff continues to provide necessary information and educational materials pertaining to transition to patients and their families.

Population Based Services
CSHS staff continue to provide age appropriate services to all transition-age patients and their families. The adolescent/young adult patient and his/or family are encouraged to attend conferences and seminars on transition services throughout the community.

Infrastructure Building Services
CSHS continues to provide information to health care professionals who work with adolescent and/or young adult patients who are transitioning and assist them with the necessary tools so they might make a successful transition. CSHS continues to implement the Long Range Plan Needs Assessment, which will provide information about resources for young adults with special health care needs.

c. Plan for the Coming Year

Objective: The goal for the upcoming year is to increase to 12% youth with special health care needs who receive the services necessary to make transitions to all aspects of adult life.

Direct Services
CSHS staff will continue to screen adolescent and young adult patients who are transition age and continue to assist them to acquire necessary services to promote self-reliance and independence. CSHS will continue to assist patients in acquiring the skills necessary so that they may be an active participant in the multidisciplinary team as early as possible so that they may acquire the skills necessary for adequate problem solving and decision-making. CSHS will continue a formal transition process to use with all adolescent/young adult patients ages 14 & 15. Patients will have an initial screening, which will be updated annually. This is a "phase in" system. Additional age groups will be added after an evaluation of the effectiveness of the program.

Enabling Services
CSHS staff will continue to provide necessary information and educational materials as well as training opportunities for adolescent/young adult patients and their families pertaining to transition services.

Population Based Services
CSHS will continue to refer young adults and/or family members to transition programs provided in communities.

Infrastructure Building Services
CSHS will continue to facilitate the educational needs of staff that work with CSHS patients reaching transition age. During the upcoming year, site visits will be held in all OPH regions to train staff in the implementation of the transition plan. CSHS will continue collaboration within the Louisiana Department of Education and Louisiana Rehabilitation Services to develop a team approach to the transition of CSHCN to adulthood and independence.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

a. Last Year's Accomplishments

Last year, immunization levels of children 24 months of age in Louisiana with 4 Diphtheria, Tetanus, acellular Pertussis (DTaP), 3 Polio, 1 Measles, Mumps, Rubella (MMR), 3 Haemophilus Influenza Type B (HiB)and 3 Hepatitis B (HBV) was determined to be 66.2% by the National Immunization Survey (NIS) compared to the national average of 73.1%. Comparable data from the 2001 NIS measure indicated Louisiana levels for 4:3:1:3:3 at 64.1% and national levels at 73.7%. The annual objective for this goal has been adjusted related to the use of the National Immunization Survey Data. In response to the falling rates, a task force was convened in 2002 to examine the variables impacting immunization rates. Recommendations of the task force have been implemented

Direct Services
Immunizations are provided in the parish health units operated by the Louisiana Office of Public Health or parish governments. Of the projected population of 476,698, from birth to 6 year olds in 2003, approximately 45 to 50% are being seen at public health clinics for immunization services. The overall immunization rate for children in public health clinics in 2003 was 47% which is lower than the State average from the National Immunization Survey.

Population-Based Services
The Vaccines for Children (VFC) program supplied publicly purchased vaccines to enrolled providers to vaccinate eligible children, including any uninsured child 18 or younger who is Medicaid eligible, American Indian or Alaskan Native. Any child who is under-insured is eligible if served through the Office of Public Health, Federally Qualified Health Center (FQHC) or a Rural Health Clinic (RHC). The enrollment of Vaccines for Children was increased to 957 enrolled vaccine provider sites. This represents a 5.2 % increase over the previous year.

Infrastructure Building Services
Efforts to increase the level of immunization for 2-year-olds include the implementation of the Immunization Registry known as "LINKS", or Louisiana Immunization Network for Kids Statewide. The Immunization Registry assists in reaching the completed immunization goals by giving providers immediate information on immunization needs of the child at the time the child is being seen. In November 2002, LINKS was honored by the American Registry Association's

"Every Child by Two" campaign as the recipient of its GROW Award. This award acknowledges an immunization program that has successfully served its state through health care provider participation, innovative marketing, and partner recruitment strategies. In 2003, LINKS was utilized in a bioterrorism drill. The July-August 2003 drill objective was to test the state's capacity to respond to a bioterrorism event while simultaneously raising the state's immunization coverage levels by utilizing the reminder recall system. The campaign was a success and as a result 11,320 children received immunizations with over 24,000 vaccinations delivered. In 2003, LINKS was nominated for the Prevention Award.

b. Current Activities

Direct Services
Immunizations continue to be provided in the public health units.

Population-Based Services
During this period the number of Vaccines for Children (VFC) providers was increased to 1,032. This represents a 7.3% increase over the previous year.

Infrastructure Building Services
The Immunization Program invested considerable effort to change legislation that would facilitate the providers' participation in LINKS. We successfully modified conflicting language, which had previously led to confusion around providing consent. OPH added a requirement that parents be notified of the existence of the registry, its purposes, benefits, and of their right not to participate.

c. Plan for the Coming Year

Objective: Increase to 74% the proportion of children through age 2 who have completed immunizations for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.

Direct Services
Immunizations will continue to be provided in the public health units.

Infrastructure Building Services
During this period, the expansion of VFC/AFIX (Assessment Feedback Incentive and Exchange) on site visits will be conducted with our provides to include education, information and quality assurance to ensure immunization best practices, increase immunization coverage levels and the simultaneous administration of vaccines. The Immunization Program will continue to work with our coalitions comprised of physicians, nurses, voluntary agencies, political leaders, churches, and community organizations. These diverse groups have come together specifically to improve immunization coverage in Louisiana, and the coalition will continue to work and oversee the Shots for Tots plan as we make progress toward our goal. The 13th annual Shots for Tots Conference is scheduled for December 2004 in New Orleans. Continuing education credit will be awarded to applying attendees who attend sessions and complete the required documentation. The goal of the conference is to provide information that will help participants to provide comprehensive immunization coverage for all age groups and to explore innovative strategies for developing programs and policy.

LINKS will continue to expand despite a temporary setback in the recruitment pace due to the smallpox phase I campaign. Plans include recruitment of 30% of the VFC providers that give 80% of the immunizations. Another plan is the receipt of data from Medicaid.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

a. Last Year's Accomplishments

In 1999, Louisiana had the 9th highest rate of live births to teens aged 15-19 in the nation with a teen birth rate of 42 per 1000 females ages 15-19 years old. In 2001, there were 3402 births to teens aged 15-17, with the birth rate at 31.8 per 1,000. This represents the 6th consecutive year in which this figure had declined, far surpassing the 2001 goal of 39.8 per 1000. In 2003, 23.8% of Family Planning clients were aged 15-19.

Direct Services
The OPH Family Planning Program (FPP) receives supplemental funding from Title V and provides comprehensive medical, educational, nutritional, psychosocial, and reproductive health care services to adolescents. Since 2000, family planning clinics statewide have been instructed to facilitate adolescent access to services by prioritizing appointments offered for women 19 and younger. Efforts to increase access have been successful. In fiscal year 2003, visits by adolescent clients increased compared to the same period in the previous year. In 2003, a total of 6,517 unduplicated patients aged 15-17 were seen in family planning clinics across the state.

Statewide, 7 sites in 4 different parishes have special clinics reserved for adolescent clients. Two contract sites in New Orleans target services to adolescents. The Planned Parenthood of Louisiana (PPLA) contract with the FPP serves clients younger than 20, and the Adolescent Drop-In Clinic specializes in adolescent health care. Both sites have seen increases in the number of clients served.

Enabling Services
Through Adolescent Health Initiative (AHI), the FPP established partnerships with over 100 community organizations, schools, and churches, presented teen pregnancy prevention information to over 16,000 teens and health professionals. Family planning education materials and information packets, including 500 "Prevent Teen Pregnancy" information packets were distributed.

Infrastructure Building Services
AHI worked with several local and state agencies to provide technical assistance on teen pregnancy prevention mass media campaigns, presentations, and school health summits. Training activities were initiated to enhance service delivery to adolescent clients. The FPP's Training Manager focused attention on adolescent services in several training sessions, including prevention of sexual coercion and adolescent health services.

Quality Assurance for family planning services includes the use of youthful "mystery callers" to assess current clinic practices regarding services to teens. "Mystery calls" conducted in August and September 2003 indicated that adolescents can be seen for initial visits within 28 days in 3 of 9 regions.

b. Current Activities

Direct Services
The Family Planning Program continues to provide comprehensive reproductive health care services to adolescents.

Enabling Services
The Family Planning Program provides outreach to young men and women in the New Orleans area through a contract with Women With A Vision, a local community based organization. A team of workers provides one-on-one and group reproductive health information. The outreach worker has made over 2000 high intensity contacts with African American men and women

aged 13-15.

Population Based Services
The Family Planning Adolescent Health Initiative staff maintains the Louisiana Teen Pregnancy Prevention Directory web site: http://oph.dhh.state.la.us/familyplanning/adhealth/index.html. The Directory allows adolescents and health professionals to stay informed about existing teen pregnancy prevention services in Louisiana.

Infrastructure Building Services
Addressing teen pregnancy rates requires addressing the concerns of teens when entering into the health care system, while at the same time encouraging parental involvement in their children's reproductive health. To reduce teen pregnancy, the Family Planning Program has developed a training program to increase clinics' ability to create teen-friendly clinics and increase the number of adolescent-specific clinic sites in the areas of the state with the highest teen pregnancy rates. Training on these issues is available to clinic staff upon request.

Quality assurance of services to adolescents will be assessed in special Quality Assurance projects conducted on a regional basis.

c. Plan for the Coming Year

Objective: Decrease birth rate to 30 (per 1000) for teenagers aged 15 through 17 years.

Direct and Enabling Services
The FPP will continue to provide reproductive health care services to teens statewide. This will be reinforced by continuing to prioritize adolescent scheduling in family planning clinics. Adolescent-specific services contracts will be initiated in the Alexandria and Monroe regions. Collaborative efforts will continue to be developed and strengthened with community based organizations working with adolescents.

Infrastructure Building Services
In an effort to increase the number of men and women under age 19 who access Family Planning services, the FPP will conduct a statewide training program and provide technical assistance on attracting adolescents to clinics.

The FPP will work toward increasing parental involvement in adolescent reproductive heath care. A qualitative research study will be conducted on the factors associated with increasing such parental involvement, and these findings will be shared at a statewide meeting/training event.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

a. Last Year's Accomplishments

Sealant data indicates a decline in the sealant prevalence for children in Louisiana. Data collected by school nurses in 1997 indicated a sealant prevalence rate of 22.8% for 3rd graders statewide. The 2003 data collected by school nurses on 3rd graders shows a 4.8% decrease in sealant utilization to 18%.

Direct Services
The LSUHSC School of Dentistry and the School of Dental Hygiene in Lafayette provided a sealant program for 1st and 2nd graders and placed a total of 574 sealants on 180 children.

Infrastructure Building Services
The Oral Health Program (OHP) provided an educational session on early childhood caries at the New Orleans Association for the Education of Young Children Conference. Oral health presentations were also made to the School-based Health Care and the Louisiana State Nursing Association Conferences; the Children's Services Collaborative, Pyramid Parent's Training, United Cerebral Palsy Association and the Childcare Director's Network.

"Bright Smiles for Bright Futures" oral health screening training program was developed to train nurses to screen children for untreated dental caries, caries experience, sealant utilization and referral rates. OHP trained 70 nurses from 11 parishes to conduct oral health screenings on 3rd grade children to determine untreated decay rates, caries experience rates, sealant utilization rates and treatment referral rate. The OHP collected oral health data on these 3rd graders. Thirty-nine schools across 7 parishes participated in the program. The following data was collected: 871 children were screened by the school nurses; 37.3% of the screened children had untreated caries; 63.5% had caries experience; 18% had dental sealants; and 37.5% of the screened children were referred for dental treatment. The OHP developed a Children's Oral Health Policy Brief. This brief was developed by a coalition of health care providers and child advocates who wanted to expose the barriers that prevent children from obtaining needed dental treatment and provide possible solutions for the elimination of these barriers. The brief was distributed to members of the Louisiana Senate Health and Welfare Committee and Finance Committee and members of the House Appropriations Committee and Health and Welfare Committee. Copies of the brief were also given to the Head Start Services Collaborative for distribution. The OHP coordinated the first statewide summit on oral health grant monies were received from HRSA, MCHB, MCH Program, Oral Health America, Louisiana Dental Association and others. The Oral Health Summit assembled health leaders and policy makers to address access and barriers to dental care, infrastructure strengths and weaknesses, educational needs, and the financing of oral health care. An important outcome of the Summit was interest in pursuing Medicaid dental coverage for pregnant women with periodontal disease. MCH worked closely with Medicaid to initiate this service.

b. Current Activities

Direct Services
The LSUHSC School of Dentistry sealant program screened 181 students from Paul L. Dunbar Elementary School and the International School of Louisiana. One hundred and forty-four students received at least one sealant and 484 teeth were sealed. Fifty-one percent of the screened children had some level of decay in one or more teeth. The LSUHSC Dental Hygiene Program sealant program in Lafayette screened 39 children and placed 90 sealants.

Enabling Services
The OHP worked with the Bureau of Health Services Financing (Medicaid) Program to provide dental coverage for Medicaid-eligible pregnant women beginning in November 2003. An educational insert was developed and is given to all Medicaid-eligible pregnant women when they receive their Medicaid packet, explaining the relationship between periodontal disease and pre-term birth and directing them to their medical provider for a dental service referral.

Population-Based Services
The OHP fluoridation program was successful in obtaining community support and establishing 2 contracts to purchase fluoridation equipment for the communities of Lutcher and Oakdale. These communities will begin fluoridating the water supply as soon as the new equipment is installed. The fluoridation program manager is working with the communities of Walker and Crowley at the present time and both communities have active fluoridation efforts on-going. Crowley's successful effort is resulting in the development of a contract for equipment to begin fluoridating that community. OHP provided educational sessions on the relationship between periodontal disease in pregnant women and pre-term low birth weight infants to Healthy Start

Family Road, pregnant women at Babies 'R' Us in Baton Rouge, a health fair at Cortana Mall in Baton Rouge and two maternity fairs at Jefferson Parish health units.

Infrastructure
The OHP is currently working with David Raines Community Health Care Center in Shreveport to provide a school-based sealant program to 200 1st, 2nd and 6th grade students The OHP is also working with the Health Enrichment Network in Oakdale to provide a school-based sealant program for 1st, 2nd and 6th graders in this parish. The OHP provided training on the new dental program for pregnant women to all medical directors and nursing staff at the 70 public health units and for the nurses at Earl K. Long Hospital in Baton Rouge. This training will continue to be provided to medical providers throughout the state through a HRSA MCH Grant received by the OHP. In addition, the grant provides money to develop a public service announcement to air across the state to help educate pregnant women about the need for good oral health during pregnancy. The OHP provided sessions on early childhood caries at the Louisiana Child Health Consultant Training Conference, the Greater New Orleans Association for the Education of Young Children Conference and Positive Steps, a training program for childcare providers.

c. Plan for the Coming Year

Objective: Increase percent of third grade children who have received protective sealants on at least one permanent molar tooth to 20%.

Direct Services

LSUHSC School of Dentistry dental sealant program and LSUHSC School of Dental Hygiene Program in Lafayette will continue to serve their respective populations in those parishes. These programs are ongoing and will continue to serve public schools in Orleans and Lafayette parishes in 2005. The OHP will continue to work with David Raines Community Health Center to expand the sealant initiative in this region of the state. The Oakdale sealant initiative will expand to other sites in Allen Parish. MCH will provide the portable dental equipment and fund the salary of the dental hygienist providing the services. Oakdale Health Enrichment Network will provide the volunteer dentists for screenings and some disposable supplies. The OHP will apply for funding opportunities to purchase portable dental equipment in order to expand the sealant program into other areas of the state.

Population Based Services
The OHP will continue to work with the Fluoridation Program to ensure that the communities of Louisiana have access to optimally fluoridated water supplies through community education, oral health initiatives that support fluoridation and local support from the local dental community. Targeted communities who express and interest in community water fluoridation will receive technical assistance and support from the fluoridation manager and fluoridation engineer. The fluoridation program will continue to monitor the water systems that are currently fluoridating to ensure the safety of the fluoridated water supplies and ensure that optimally fluoridated water with its decay-reducing benefits are delivered to the residents of Louisiana.

Infrastructure Services
The OHP will continue to monitor and evaluate the effectiveness of the dental Medicaid Program for pregnant women. This program is aimed at reducing periodontal disease in pregnant women and possibly reducing their risk of delivering a preterm low birth infant. Training on this new program will continued to be offered to medical providers throughout the state. The OHP will provide education in this area to pregnant women by working with public health units and other community gatekeepers that have access to this population.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

a. Last Year's Accomplishments

In 2002, 65 children aged 0-14 years were killed in motor vehicle crashes for a rate of 6.7 deaths/100,000 children which was even better than the desired goal of 7.0 deaths/100,000 children The Maternal and Child Health (MCH) Program and the Bureau of EMS/Injury Research and Prevention Section (EMS/IRP) work toward reducing child vehicular deaths. MCH provides funding to Louisiana SAFE KIDS and funds the 9 Regional Maternal and Child Health Injury Prevention (MCHIP) staff.

Population-Based Services
The MCHIP program and LA SAFE KIDS provided approximately 20 child restraint check-up events where caregivers got direct hands-on help in their vehicle with their safety seat. Each LA SAFE KIDS and Regional MCHIP Coordinator participated in at least one check-up event monthly, often in coordination with other members of the Louisiana Passenger Safety Task Force.

The MCHIP Program and LA SAFE KIDS offered child restraint technical assistance and educational outreach through health fairs, seminars, and workshops. Media outreach was carried out through newsletter submissions and television interviews. Community outreach was accomplished through dissemination of educational material such as brochures, pamphlets, and presentations to various groups such as childcare centers, head start facilities, health fairs, schools, and faith-based groups. In 2003, the MCHIP Coordinators gave 300 public presentations reaching approximately 6000 people; provided professional education to approximately 5700 teachers, nurses, and child care center staff; and conducted risk Watch educational activities for children in 300 classrooms reaching 9000 children.

Infrastructure Building Services
EMS/IRP Section has provided staff support and mentored the 9 regional MCHIP staff.

LA SAFE KIDS analyzed data from the community-based check-up events and compiled an annual report with the data. LA SAFE KIDS regularly supports legislative initiatives that support injury prevention. LA SAFE KIDS supported a bill reintroduced this legislative session that specifies appropriate child restraints by weight and age. The bill passed in the summer of 2003 and was signed into law and became effective January 1, 2004.

The MCHIP Program reviewed existing injury prevention resources from National Highway Traffic and Safety Administration, American Academy of Pediatrics, Centers for Disease Control, Risk Watch, and The National SAFE KIDS Campaign. Information from these programs were tailored to fit the specific needs of agencies and communities that serve school-aged children in the state of Louisiana. Information addresses, but is not limited to, the importance of wearing seat belts, pedestrian and traffic safety and included fact sheets regarding data specific to motor vehicle crash injuries, prevention tips, and Louisiana laws.

b. Current Activities

Population-Based Services
During the first six months of the 2003-2004 fiscal year, approximately 10 child restraint check-up events have been organized throughout the state, with collaboration from the Louisiana Passenger Safety Task Force and Louisiana Highway Safety Commission. From 1998-2003, a total of 4,658 seats were checked. Ninety percent of the rear-facing seats were used incorrectly, 93% of the forward facing seats were used incorrectly, 40% of the belt positioning booster seats were used incorrectly, 93% of the shield booster seats were used incorrectly, and 78% safety belt systems were misused.

Infrastructure Building Services
The MCH Program continues in its support of the Regional MCHIP Coordinators.

In addition to the State Child Death Review Panel for which the MCH Program provides staff support, local Child Death Review Panels have been established in all 9 regions of the State through the OPH Regional staff and the Regional MCHIP Coordinators. The multi-disciplinary State and Local Child Death Review Panels review all unexpected deaths of children under the age of 15. Information collected by the Child Death Review Panel is used to determine preventive interventions that can decrease motor vehicle as well as other unexpected childhood deaths.

LA SAFE KIDS has developed information sheets explaining the new law relative to the use of appropriate child restraints by age and weight. This law became effective January 1, 2004

c. Plan for the Coming Year

Objective: To decrease to 6.7 per 100,000 the rate of deaths to children aged 14 years and younger caused by motor vehicle crashes.

Population-Based Services
LA SAFE KIDS will continue to conduct and/or assist with monthly check-up events, while MCHIP staff will increase participation in regional check-up events to twice monthly. Presentations to schools, daycare centers, and community-based organizations will be conducted twice monthly in each of the nine regions of the state.

Infrastructure Building Services
To facilitate this process, staff from EMS/IRP, MCHIP, and LA SAFE KIDS will continue to conduct local injury prevention activities related to the establishment of community-wide child motor vehicle occupant injury programs with special emphasis on populations at high risk.
In order to reach our objective, the MCH program will continue to collaborate with the OPH EMS/ Injury Research & Prevention Section on prevention programs and support of the Louisiana SAFE KIDS and MCHIP programs. These programs will continue to provide technical as well as educational resources for populations at heightened risk for injuries and or deaths resulting from motor vehicle crashes. Additionally, programs will continue to collaborate with epidemiology colleagues to produce reports that will assist the Louisiana Office of Public Health in conducting interventions.

Performance Measure 11: *Percentage of mothers who breastfeed their infants at hospital discharge.*

a. Last Year's Accomplishments

The most current available data from the LA Pregnancy Risk Assessment Monitoring System (LaPRAMS), collected for 2001, reports 45.9% of mothers' breastfeeding at hospital discharge. The rate has been steadily increasing over the past several years, as have national breastfeeding rates. From 1997 to 2001, the rate has increased by more than 8%, which compares to most of the states in this region. Nationally breastfeeding rates are the lowest among African American women. Approximately 42% of live births of in Louisiana are to African American women, as compared to 15% nationally and 2-20% regionally.

Enabling Services
Each WIC Clinic has a designated Breastfeeding Coordinator (nutritionists, health educators, and nurses) who received additional breastfeeding training beyond that of other clinic staff. The coordinators participate in community based outreach efforts with groups such as La Leche League, hospitals, breastfeeding task forces and committees in order to increase breastfeeding among the WIC population. Hospital grade electric, portable electric and manual breast pumps were provided by the parish health units and other WIC sites, assisting over 3,000 breastfeeding women.

Infrastructure Building Services
The Louisiana WIC Program applied for and received a national grant in September 2003, "Using Loving Support to Build a Breastfeeding-Friendly Community". A component of the grant includes a two-day conference with community-based partners to be conducted by a national social marketing company.

A multivariate analysis of LaPRAMS data was conducted to determine the effects of hospital breastfeeding counseling and practices on length of breastfeeding in Louisiana. The study found that a woman is less likely to continue breastfeeding in the following cases: if she was given a formula gift pack at the hospital (OR 6.67, CI 4.53-9.83); if she was not given a telephone number to call for help with breast-feeding (OR 7.67, CI 6.14-9.59); if hospital staff did not provide her with information about breast-feeding (OR 2.87, CI 2.03-4.06); if her baby was not in the same room with her (OR 1.38, CI 1.13-1.68); if she is Black (OR 3.16, CI 2.49-4.00); if she has 12th grade or less education (OR 1.85, CI 1.49-2.29); if she is unmarried(OR 2.01, CI 1.60-0.53); if she lives in a rural area (OR 1.72, CI 1.42-2.08).

b. Current Activities

Enabling Services
WIC sites continue to create positive clinic environments that endorse breastfeeding as the preferred method of infant feeding. Sites provide culturally appropriate breastfeeding educational videos, handouts and posters. Structured breastfeeding classes are offered to prenatal, postpartum and breastfeeding participants. Breastfeeding support and education information is provided to family members of breastfeeding clients. Hospital grade electric, portable electric and manual breast pumps continue to be provided to parish health units and other WIC sites to assist breastfeeding participants.

Population-Based Services
Clinic Breastfeeding Coordinators are participating in outreach efforts with community-based groups through health fairs and educational trainings. A toll-free 24-hour breastfeeding helpline has been funded by MCH to be initiated in conjunction with the upcoming national Ad Council Breastfeeding Project through a combined effort between Woman's Hospital in Baton Rouge, Tulane University-Xavier National Center of Excellence in Women's Health, MCH, Partners for Healthy Babies and the WIC Program. In conjunction with the Ad Council's campaign, WIC will provide components of the "Loving Support " breastfeeding campaign utilizing media to increase breastfeeding awareness, and by distributing a total of 1600 "Physician Breastfeeding Support Kits" statewide to Obstetricians and Pediatricians. The kit includes items such as

"Breastfeeding Management: A Quick Reference Guide for Physicians", "How to Breastfeed: A Guide for Mother", "Questions and Answers: What Moms Want to Know", "Working and Breastfeeding: A Guide for Mothers", "Building a Breastfeeding Support Team: A Guide for Physicians", and a patient letter encouraging mothers to breastfeed.

Infrastructure Building Services
Louisiana WIC received a national grant, "Using Loving Support to Build a Breastfeeding-Friendly Community". A comprehensive, community-based initiative to improve breastfeeding rates was developed as a component of the "Loving Support" grant to include staff and community training and breastfeeding awareness and support at community events. Professional and paraprofessional staff will receive training at the annual Breastfeeding and Nutrition Education workshop. A national speaker will present current issues and trends in breastfeeding at the annual conference. A report using LaPRAMS breastfeeding data from years 1998-2000 was presented at the National Maternal and Child Health Epidemiology Conference, highlighting the effect of the WIC program participation on breastfeeding practices among Louisiana mothers.

c. Plan for the Coming Year

Objective: Increase to 48% the proportion of Mothers who breastfeed their infants at hospital discharge.

Enabling Services
All WIC sites will continue to create clinic environments that endorse breastfeeding as the preferred method of infant feeding. Sites will provide culturally appropriate breastfeeding educational videos, handouts and posters. Structured breastfeeding classes will be offered to prenatal, postpartum and breastfeeding participants. Breastfeeding peer counselors will be utilized in each region of the state as part of the on-going breastfeeding initiation and support effort. Combining peer counseling with the on-going WIC breastfeeding promotion efforts has the potential to significantly impact breastfeeding rates among WIC participants, and, most significantly, increase the harder to achieve breastfeeding duration rates.

Population Based Services
Regional Breastfeeding Coalitions will be established statewide, including WIC, faith-based organizations, and other health care providers. Breastfeeding awareness information and support will continue at the community level, including faith-based organizations, daycare and head start programs, physicians, other health care providers and community events. All activities described above will continue.

Infrastructure Building Services
A new statewide resource guide will be developed to include updated information on WIC Clinic Breastfeeding Coordinators, local La Leche League groups and leaders, hospitals and individuals statewide offering breastfeeding services. Breastfeeding information and links will be included on the Nutrition Services Website.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

a. Last Year's Accomplishments

The Hearing, Speech and Vision's "Sound Start" Early Hearing Detection and Intervention program has made increased hearing screening for newborns a priority. The goal of this program is to increase the proportion of newborns that are screened for hearing loss by 1 month of age, have audiological evaluation by 3 months of age, and receive appropriate early

intervention services by 6 months of age. By reaching these goals, the program seeks to reduce the morbidity, development delay and educational delay associated with hearing loss. During the fiscal year 2002, the program exceeded the objective of 70.0% of newborns screened for hearing loss, with 82.4% of newborns (49,865 out of 60,494) being screened for hearing loss before hospital discharge. During fiscal year 2003, the program has continued to exceed previous expectations, with 92.4% of newborns (59,690 out of 64,575) screened. The annual performance objective was 85.0%.

Direct Services
Follow-up services were provided by Hearing, Speech and Vision's audiologists to perform audiological evaluations for children who do not pass the hospital hearing screening and cannot be evaluated in the private sector due to lack of insurance or no access to local community services. Audiologists with the Hearing, Speech and Vision program provided 905 audiological evaluations to infants across the state. Hospital-based screening programs at all birthing hospitals in the state provide direct newborn hearing screening services.

Enabling Services
The Sound Start program provided parent brochures about newborn hearing screening to hospital programs for dissemination to new parents. The program also facilitated a Parent Support group in the New Orleans area to provide support to families of children with hearing loss.

Population-Based Services
The Sound Start program is a population-based program that screens all babies born in Louisiana for hearing loss before hospital discharge. State law mandates universal hearing screening. Hearing screening for newborns is performed at each of the 67 birthing hospitals in the state. State law requires that hospitals report screening results to the Sound Start program.

Infrastructure Building Services
The Sound Start program provided infrastructure building services to birthing hospitals across the state to allow hospitals to accomplish this Performance Measure. Sound Start personnel provided quarterly and annual data reports to hospitals for monitoring purposes. Sound Start personnel also provided training and technical support to hospital personnel for testing, reporting data, and linking families to follow-up services. During fiscal year 2002, the program developed standards for hospital-based screening programs that detailed the legal requirements and recommended procedures for effective programs. During fiscal year 2002, the program also improved its Sound Start database to allow for more effective monitoring and evaluation of screening programs.

b. Current Activities

Direct Services
Follow-up services continue to be provided by Hearing, Speech and Vision's audiologists in audiology clinics throughout the state. Direct screening services continue to be provided by hospital-based screening programs at all birthing hospitals in the state.

Enabling Services
In addition to providing parent brochures about newborn hearing screening to hospital programs for dissemination to new parents, the Sound Start staff is also working on brochures designed for families of babies who refer for further testing and general informational brochures for distribution in prenatal classes. An additional Parent Support group has started in the Northshore area of the state, as well. Focus groups have been held in two regions of the state and are planned in the other seven regions. These focus groups seek to collect more information on the opinions of these families and on the barriers and successes they face in getting services for their children. The Sound Start Program has implemented a referral

process to the EarlySteps System to assure early intervention is accomplished for children identified with hearing loss.

Population-Based Services
To supplement universal hearing screening for newborns performed at each of the 67 birthing hospitals in the state, the Sound Start program is working on developing an improved Tracking and Follow-up System. This system will track babies who fail the newborn hearing screening and will ensure that these newborns get follow-up audiological evaluation and, if identified with a hearing loss, early intervention services, including hearing aid evaluation and educational services.

Infrastructure Building Services
Sound Start personnel continue to provide quarterly and annual data reports to hospitals for monitoring purposes as well as training and technical support to hospital personnel for testing, reporting data and linking families to follow-up services. The lowest performing hospitals are targeted, based on the percentage of newborns screened for hearing loss during birth admission and the percentage of newborns referred for further testing. During the current fiscal year, the program is developing standards for pediatric audiological evaluation and guidelines for early intervention programs that serve infants and toddlers with hearing loss. The program continues to update and improve its Sound Start database to allow for more effective monitoring and evaluation of screening programs. Additional training will be provided later this year to hospital screening supervisors. The training goals will be based on the specific needs of the supervisors. This information is currently being gathered through a survey of all hospital program supervisors in the state.

c. Plan for the Coming Year

Objective: To increase to 95% the proportion of newborns who are screened for hearing loss before hospital discharge.

Direct Services
Screening and follow-up services continue as stated previously. The Speech, Hearing and Vision program is will continue to work to establish partnerships in the private sector throughout the state.

Enabling Services
The Sound Start program will extend the distribution of all pamphlets for parents. Pamphlets focus on information for new parents, expectant parents and parents of newborns who refer for further testing. An informational packet of materials will be developed for distribution to families of babies identified with a hearing loss. The Sound Start program will also disseminate informational pamphlets to pediatricians to educate and inform them about newborn hearing screening. The program will continue to support Parent Support groups for families of children with hearing loss and will extend support groups into other areas of the state.

Population-Based Services
Birthing hospitals in Louisiana will continue to strive to meet the goal of universal screening -- that every baby born in Louisiana will be screened for hearing loss before 1 month of age. The program will continue to collect data on newborn hearing screening and will implement a follow-up system to ensure that all infants who do not pass a hearing screening receive appropriate follow-up services.

Infrastructure Building Services
Monitoring activities, training, and technical support services are ongoing. Monitoring and evaluation of statewide Sound Start program will intensify as we seek to continuously improve our services and meet all of our goals. Models of service delivery and seamless systems for

children with hearing loss will be evaluated in 2 regions of the state and duplicated in 2 additional regions in the next year. We will provide educational training to audiologists and physicians throughout the year. As Louisiana's Early Steps early intervention program develops, we expect that a closer coordination of newborn hearing screening and early intervention services will allow Louisiana to improve follow-up rates and assure that children receive needed services by 6 months of age.

Performance Measure 13: *Percent of children without health insurance.*

a. Last Year's Accomplishments

The percentage of uninsured children from birth to 19 years decreased from 13.3% to 12.4% in 2002, which is below our 2002 target of 15%. This is an estimate from the American Academy of Pediatrics' analysis of the Census Current Population Survey, which has been used for this measure from 1997 through 2001. This is similar to other studies of uninsured children in Louisiana. A study of 10,000 households in Louisiana done by the Department of Health and Hospitals in 2003 indicated that the percent of uninsured children was 11.1% with the percentage for children under 19 years in families with incomes less than 200% of Federal Poverty level at 12.9%. Another study done by the Louisiana Department of Social Services, of 2000 low income families with incomes less than 200% of Federal Poverty Level, found that 13% had at least one child without health insurance.

This decease in uninsured children has been primarily due to the efforts of the Louisiana State Child Health Insurance Program, LaCHIP, which has expanded income eligibility in the Medicaid Program up to 200% of Federal Poverty Level for children up to 19 years of age. The number of children receiving Medicaid benefits through the LaCHIP Medicaid expansion has nearly doubled, from 40,646 on January 1, 2001 to nearly 87,000 children in August 2003.

Enabling Services
All clients attending one of the 70 Public Health units for WIC or other Child Health services are screened for income eligibility for LaCHIP/Medicaid. Clients who are income eligible and are currently uninsured are provided information on LaCHIP/Medicaid and the application brochure. At subsequent visits LaCHIP/Medicaid eligibility is determined and further information and assistance is offered to those who are still eligible but remain uninsured.

Population-Based Services
With the ending of the Robert Wood Johnson (RWJ) grant in August 2002, outreach activities have been transferred to Agenda for Children's Covering Kids and Families Initiative. The goals of this Program are to 1) coordinate and conduct outreach; 2) simplify enrollment and renewal processes, and 3) coordinate health coverage programs. The MCH Program continued to work with Agenda in support of their outreach activities.

Infrastructure Building Services
The MCH Program maintains a working relationship with the State Medicaid and LACHIP staff and remains a resource to provide technical information and assistance. The MCH Program also works with Medicaid staff in providing updated information to the 70 Office of Public Health clinics throughout the State.

b. Current Activities

Information from surveys conducted in 2003 related to the uninsured referred to above has been recently released. The high percentage of uninsured adults as well as Regional differences in rates of uninsured children indicate the need to increase outreach efforts in those areas with the highest uninsured rates for children.

Enabling Services
The Office of Public Health clinics continues screening for income eligibility for LaCHIP/Medicaid and referral of infants and children who are eligible for these programs. In addition, OPH screens for income eligibility for pregnant women who come to Public Health Units for WIC or other health services and provide them application and referral information. In January 2003, Medicaid income eligibility was increased from 133% of the Federal Poverty Level to 200%, initiating a new effort entitled LaMOMS. This is the first increase in over a decade.

Population-Based Services
The MCH Program continues to work with Agenda for Children's Covering Kids and Families Initiative in support of their outreach activities through the Statewide as well as Local Coalitions. There are currently Regional Coalitions located in the Northeast, Northwest, Central and Southeastern parts of the State with plans underway to establish Regional Coalitions in 3 other areas of the state. The work of the Regional coalitions should help to decrease the regional differences in rates of uninsured children.

Infrastructure Building Services
The MCH Program remains a resource to provide technical information and assistance to the LaCHIP and Medicaid Programs, in addition to working with Medicaid staff in providing updated information to the 70 Office of Public Health clinics throughout the State.

c. Plan for the Coming Year

Objective: Decrease the percentage of uninsured children to less than 12%.

Enabling Services
We will continue screening and referral of those uninsured infants, children and adolescents who are eligible for LaCHIP/Medicaid services as well as pregnant women to LaMoms.

Population-Based Services
The MCH Program will continue to work with Agenda for Children in their outreach efforts.

Infrastructure Building Services
The MCH Program will continue to work with the Medicaid Program in providing technical assistance and information, particularly in addressing issues of access to service.

With a change in the Governor of the State in 2004, a Health Summit was held in March of this year. One of the major findings of the Summit was the high number of uninsured adults and lack of primary health services for many adults as well as children in the State. MCH Staff participated in the Summit and will continue to support efforts to increase health care coverage and access to health care for Louisiana's MCH populations.

Performance Measure 14: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

a. Last Year's Accomplishments

An estimated 78% of potentially Medicaid eligible children actually received a Medicaid-paid for service in 2002. This is an increase from 71% in 2001 even with an increase of 31,000 in the potentially eligible from 680,244 to 701,643. The actual number of recipients of services increased from 480,823 to 547,454. The increase probably is due to the full impact of increasing income eligibility to 200% of Federal Poverty Level under CHIP that occurred on

January 1, 2001. Also by October 2003, Community Care, Louisiana's Primary Care Case Management for Medicaid clients, was implemented in most of the State. This program links each Medicaid enrolled client to a primary care health care provider for provision and coordination of health care. For infants, children and adolescents, this includes assuring each receives EPSDT screening services.

Direct and Enabling Services
The MCH Program provides comprehensive preventive child health services in the parish health units to children whose families are uninsured or are Medicaid eligible and have no access to private care. All children receiving services are screened for Medicaid/LaCHIP eligibility and are provided applications for enrollment if found eligible. MCH has a contract with Medicaid to conduct EPSDT screening in parish health units particularly in areas of the state where there is limited provider availability. In some of the Community Care parishes, Parish Health Units contract with Community Care Providers to perform these EPSDT services. In FY 2003, 6680 screening visits for infants and children were conducted through the Parish Health Units. MCH has also supported community based child health programs that provide pediatric primary care.

Population-Based Services
The MCH Program Director was on the Advisory Board for the Agenda for Children's Covering Kids and Families Project. The goals of this Program are to: 1) coordinate and conduct outreach 2) simplify enrollment and renewal processes, and 3) coordinate health coverage programs. As an Advisory Board Member, she has had input into the outreach efforts of this program.

Infrastructure Building Services
The MCH Program has worked with the Regional Offices and Parish Health Units in dissemination of information related to the implementation of Community Care. MCH staff served on a Medicaid task force to facilitate the rollout of Community Care in New Orleans by linking Medicaid staff with community-based preventive health and social service providers.

b. Current Activities

Direct Services
The Office of Public Health continues to provide screening services to low income child health patients who do not have a private health care provider through the Parish Health units. In some areas of the state, screening services for Medicaid infants and children are being provided in the parish health units through contracts with Community Care physicians.

Enabling Services
The Office of Public Health continues to screen for income eligibility for the Medicaid and LaCHIP Programs and provides information and application materials to those found eligible.

Population-Based Services
The MCH Program continues to support the efforts of Agenda for Children's Covering Kids and Families Project.

Infrastructure Building Services
With the shift in direct services in most parts of the State to the private sector, the MCH Program is continuing to work with Regional and Parish Health Unit staff in assuring that clients receive needed services from private health providers. The MCH Program also works with Medicaid and Community Care Administrative staff in addressing issues that arise in clients receiving services.

A Needs Assessment is being conducted by the Children's Special Health Services Program,

which will provide information as to the current capacity of primary and specialty health care providers, to care for uninsured and Medicaid enrolled children as well as children with special health care needs. Through this Needs Assessment, capacity in each region of the State will be determined and mapped.

c. Plan for the Coming Year

Objective: Increase to 80% the percent of potentially Medicaid-eligible children have received a service paid by the Medicaid Program.

Direct Services
The MCH Program will continue to support the provision of comprehensive preventive health services in the Parish Health units for uninsured clients as well as those who have limited access to such services. In Community Care Parishes, screening services for Medicaid infants and children will continue to be provided in the parish health units through contracts with community health providers.

Enabling Services
The MCH Program will continue to screen for income eligibility for the Medicaid and LaCHIP Programs and provide information and application materials to those found eligible.

Population-Based Services
The MCH Program will continue to support outreach efforts for the Medicaid/LaCHIP Programs through working with Agenda for Children's Covering Kids and Families Project.

Infrastructure Building Services
The MCH Program will continue to work with Regional and Parish Health Unit staff in addressing issues related to the implementation of Community Care. MCH medical and nursing consultants will work with the field to update maternity and child health protocols and manuals, provide training to parish public health unit staff, and monitor CQI performance measures and statistics.

As a part of the Early Childhood Comprehensive Systems Building Initiative, a State Plan for the implementation of such a comprehensive system will be completed. Access to health care and a medical home for all children will be a part of that plan for young children.

The MCH Child Health Medical Director will continue to work with the State EPSDT (KIDMED) Program, the Medicaid Program, and the Louisiana Chapter of the American Academy of Pediatrics Executive Committee to address issues and concerns related to the State's Medicaid and Community Care Programs and access and availability of care for all children.

Performance Measure 15: *The percent of very low birth weight infants among all live births.*

a. Last Year's Accomplishments

Reversing a prior trend, the 2002 very low birth weight (VLBW) rate dropped to 2.1%, down from 2.3% in 2001.

Direct Services
MCH provided prenatal services through 70 parish health units (PHU), some providing comprehensive care and all providing pregnancy testing, nutritional, and WIC services. Twelve additional sites offered prenatal services through contract agencies, in areas identified as high need and limited provider resources.

Enabling Services
Approximately 19,400 pregnant women who received prenatal care from private providers obtained WIC benefits and health education from the PHU. The Prenatal Risk Assessment Screening Tool (PRAsT)was piloted, assessing medical and social factors that may result in preterm birth, including screening for substance use.

MCH contracted with Medical Center of Louisiana - New Orleans to address substance abuse in pregnancy. Toxicology screens on 3295 pregnant women revealed over 14% having a positive screen for one or more drugs. Over 1200 women were screened with the 4Ps plus tool. Cessation treatment services were provided to 140 women. Baton Rouge, Shreveport, and Alexandria continued to be a focus of MCH collaboration due to high infant mortality rates. MCH initiated similar efforts in 6 parishes with the next highest numbers of perinatal deaths. Interventions were aimed at addressing outreach, case management, Nurse Family Partnership (NFP), Fetal Infant Mortality Reviews (FIMR), and prenatal care access.

MCH addressed gaps in smoking cessation services for perinatal populations through a contract with the American Cancer Society (ACS). ACS trained 22 facilities (19 public health and 3 private providers) in a prenatal smoking cessation counseling program. One hundred public providers and 31 private providers were trained. The program screened ~3,750 pregnant women, and counseled ~850 pregnant smokers with an additional 5% smoking cessation success rate.

Population-Based Services
The Partners for Healthy Babies public information campaign linked pregnant women to health and social service providers via a toll free referral helpline. A statewide public relations promotion promoted appropriate pregnancy weight gain.

Infrastructure Building Services
Previous PRAMS data identified inappropriate weight gain and lack of nutritional counseling as important risk factors for low birth weight. To increase nutrition counseling, a presentation on prenatal weight gain was given to over 100 nutritionists at the WIC Nutritionists Conference. Over 1,000 providers were furnished educational materials and a tool to calculate proper weight gain.

Birth-death linked files were analyzed, with mapping of mortality rates and resources targeted to those areas. OPH initiated and supported the development of regional FIMR groups, with 5 regions (II, V, VI, VII, VIII) in the process of implementing the reviews and plans for centralized data registry.

b. Current Activities

Direct Services and Enabling Services
The direct services described above continue. MCH funded a New Orleans Healthy Start Program to fill gaps in case management services in high-risk areas no longer served by the program.

The PRAsT is now utilized in two Regions. Region VIII is collaborating with the Office of Addictive Disorders in screening and treatment for women with substance abuse. Tobacco use screening and cessation programs are ongoing statewide. ACS maintains relationships with providers previously trained. The ACS program screened 2,800 pregnant women and counseled 680 who smoked, with a 5.6%

additional cessation success rate.
MCH and Medicaid began a dental services program for Medicaid-eligible pregnant women, targeting women with signs of periodontal disease. Information is given to every newly enrolled Medicaid pregnant woman. Informational packets were sent to providers in the state.

Population-Based Services
The Partners for Healthy Babies public information campaign featured proper prenatal weight gain beginning in October 2003. The lead article in the October 2003 issue of the Louisiana Morbidity Report was on the significance of prenatal weight gain. The new Medicaid coverage for dental services is promoted through Partners.

Infrastructure Building Services
The Louisiana Fetal & Infant Mortality Reduction Initiative (FIMRI) is coordinating multiple agencies to fully assess resources, analyze data, and coordinate more effective interventions. Regional FIMRI coordinators are establishing infrastructure for assessment, policy development, and implementation issues. Contracts are in place in all regions, to establish a FIMR panel, a lead coordinator, outreach, and NFP services in the highest mortality areas.

MCH helped fund a randomized control study by Tulane University, to evaluate the NFP Program. In comparison to a "usual care" sample, NFP participants had improved measures in: less alcohol use during pregnancy (17% reduction of any use, and 51% less intoxication; NFP with 52% fewer preterm infants; NFP group showed a 42-gm increase in birth weight; and NFP women age < 19, had an 81-gm increase in birth weight.

MCH provided training on the relationship between periodontal disease in pregnant women and VLBW and the new Medicaid dental coverage statewide, with provider education, direct mailing to physicians, and information to the state ACOG meeting.

A 2nd annual Perinatal Epidemiology & Infant Mortality Reduction Meeting was held in November 2003 addressing Perinatal Periods of Risk, MCH indicators, and presentations of successful programs in other states. All regions participated, including public health medical directors, epidemiologists, and providers. The University of Alabama Perinatal Health faculty led a needs assessment and strategic planning session with regional breakout sessions.

A study to compare 2 diagnostic methods for Gonorrhea and Chlamydia in 650 pregnant women was completed at 3 si

c. Plan for the Coming Year

Objective: The proportion of very low birth weight live births will be maintained at 2.2%.

Direct and Enabling Services
Direct and enabling services described above will continue. An increase in the number of prenatal patients and visits is expected due to the expansion of clinic sites. The NFP Program will expand as a new program in 6 parishes.

The PRAsT will expand to other regions of the state after minor revisions based on analysis of the piloted regions. An evaluation method of the tool's use and

effectiveness will be developed and implemented.

Population-Based Services
The Partners for Healthy Babies public information campaign will continue to increase the awareness of good oral health during pregnancy and the importance of appropriate weight gain, with a targeted media campaign.

Infrastructure Building Services
The new statewide Louisiana Fetal & Infant Mortality Reduction Initiative will expand efforts, in conjunction with the network of Regional FIMRI coordinators. Leadership will conduct regular meetings of this network to assist FIMR, conduct a needs assessment and in strategic planning. The Medical Director will institute a statewide program of direct visits to provider offices of high-risk obstetrical populations, for provider education about outcome data and strategies to prevent preterm births. There is a goal for Regional Perinatal Associations throughout the state, and the framework for their implementation will be developed.

The 3rd Epidemiology & Infant Mortality Reduction Initiative statewide meeting will take place November 2004. Quarterly educational videoconferences will be conducted for OPH and contract providers.

Newly available 2001 and 2002 PRAMS data will be analyzed and the reports distributed. The updated MCH Data book will be distributed, birth-death linked file will be analyzed, and the data will be presented.

The work begun with Medicaid coverage of pregnant women for dental services will be enhanced, with further provider outreach and data analysis. The weight gain in pregnancy initiative will undergo a strategic planning process to identify methods to better target providers and patients.

Negotiations have been initiated for a Medicaid waiver to allow Family Planning services to continue for women for two years after delivery. Steps to establish a Pregnancy Associated Mortality Review process will begin.

An enhanced and more coordinated effort is being planned for smoking cessation. MCH is collaborating with the Tobacco Control Program and the Louisiana Campaign for Tobacco Free Living to develop and implement a comprehensive, strategic plan to expand evidence-based programs addressing tobacco use in pregnancy.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

a. Last Year's Accomplishments

Adolescent suicide is the 3rd leading cause of death for adolescents nationally and in Louisiana. However, in Louisiana, the rate of adolescent suicide has been lower than the annual performance objective for the last five years. The 2002 rate of suicide deaths among youth ages 15-19 has declined from the 2001 rate. In 2001 the rate of suicide deaths among youth ages 15-19 was 9.2 per 1000 and the rate in 2002 was 7.6 per 1000.

Direct Services
The Adolescent School Health Initiative (ASHI) Program, a statewide network of School-Based Health Centers (SBHCs), collaborated with the State Office of Mental Health (OMH) to provide

mental health counseling and a mechanism for referral. In 2002-2003, two of the SBHCs had OMH staff working on site. Each SBHC has a formal suicide prevention protocol in place. A statewide uniform encounter form based on ICD-9 codes was implemented in the 1997-98 school year to assist in determining the extent of depression among children at schools with SBHCs and in developing intervention strategies.

Infrastructure Building Services
In January 2001, the Adolescent Health Initiative (AHI), in conjunction with the ASHI Program and several other agencies, formed the Louisiana Youth Suicide Prevention Task Force. A statewide suicide prevention plan was formulated, with the priorities of the plan focusing on suicide prevention for Louisiana youth through the training of gatekeepers, awareness campaigns, and advocacy efforts. At the end of 2002, the Gatekeeper Trainings reached 400 school, health and community professionals in all nine regions of the state. As a result of the suicide prevention legislation that was passed in 2001, the inaugural edition of the Louisiana School Plan to Prevent Youth Suicide was developed during the 2001-2002 school year, incorporating four hours per semester of suicide prevention into state health education benchmarks. In February 2003, the Louisiana Board of Secondary Education (BESE) unanimiously passed the school plan.

The Task Force facilitated the governor's proclamation of September 21-27, 2003 as the 3rd Yellow Ribbon Youth Suicide Prevention Week in the state of Louisiana with activities to raise awareness conducted such as the provision of Suicide Prevention Awareness packets to Louisiana schools, a statewide Suicide Prevention essay and poster contest, an awards luncheon in the Baton Rouge area, and numerous media reports. Many schools had their own activities such as poetry contests, youth talk sessions, and awareness events.

b. Current Activities

Direct Services
The Adolescent School Health Initiative (ASHI) Program continues to provide direct mental health counseling and referral to Louisiana's youth. There are 51 state-funded SBHCs, 1 federally funded SBHC, and a SBHC funded by the Rapides Foundation in the state, providing access to nearly 50,000 students. Mental health concerns are among the top 3 most common reasons for visits to SBHCs in both urban and rural areas of Louisiana. The centers continue to collaborate with the State Office of Mental Health (OMH) to provide mental health counseling and a mechanism for referral, as well as to obtain technical assistance and quality assurance evaluations.

Infrastructure Building Services
The Louisiana Youth Suicide Prevention Task Force, chaired by the Adolescent Health Initiative will continue to administer monthly planning meetings of the 25-member task force, to attend quarterly meetings of the Department of Education's School Subcommittee on Youth Suicide, and to serve as a statewide resource on youth suicide prevention to various community--based agencies, faith-based institutions and youth serving agencies. Additionally, the task force has provided technical assistance and expertise for the Center for Disease Control/Suicide Prevention Resource Center/Children's Safety Network, Federal Region VI & IV's Suicide Prevention Conference that occurred December 3-5, 2003. The Task Force helped by facilitating sessions, organizing Tulane student volunteers and presenting the Louisiana Strategic Plan to Prevent Youth Suicide.

The Task Force continues to conduct a series of Gatekeeper Trainings in order to reach school personnel. At the end of 2003, the Gatekeeper Trainings and multi-parish planning Summits reached 759 school, health and community professionals in all 9 regions of the state. Also the task force is continuing to conduct 5 multi-parish planning summits to mobilize community leadership around the topic of youth suicide prevention.

Lastly, the Louisiana School Plan to Prevent Youth Suicide has been approved by the Louisiana Board of Secondary Education (BESE) and preparations are being made for its implementation during the upcoming fall school semester.The Governor's Suicide Prevention Week in May 2004 will include the 1st Louisiana youth walk against suicide, multi-parish planning summits for multi-disciplinary professionals, the Suicide Prevention Day at the Capitol and statewide press release. Also in 2004, the task force is working on the 4th Annual Yellow Ribbon Youth Suicide Prevention Week on September 19-25, 2004 with similar activities that were conducted in 2001-2003. The establishment of the first Louisiana college Yellow Ribbon chapter has been established at Southeastern University in Hammond, Louisiana.

c. Plan for the Coming Year

Objective: Decrease the rate of suicide deaths among youths 15-19 to 7.4 (per 100,000).

Direct Services
Through the ASHI Program, the SBHCs will continue to collaborate with the State Office of Mental Health (OMH) to provide mental health counseling and a mechanism for referral. ASHI has requested additional funding from the State Legislature to plan eight new SBHCs in 2004-2005, which would become operational in 2006.

Infrastructure Building Services
The Louisiana Youth Suicide Prevention Task Force, chaired by the Adolescent Health Initiative will work collaboratively with the Department of Education's School Subcommittee and Baton Rouge Crisis Intervention Center to plan and administer Gatekeeper trainings in the coming year. These will focus on school professionals, such as teachers, nurses, coaches, counselors, social workers, and resource officers. One Gatekeeper training of fifty school professionals will be conducted in each of the nine regions of the state, ultimately reaching 450 school professionals.

In addition to the trainings, the task force and its member agencies will plan and administer Multi-Parish Planning Summits that will be conducted in five areas of the state in order to bring together fifty participants per meeting, representing various disciplines from within the schools and the community. Previously trained Gatekeepers will be reconvened and updated on the Suicide Prevention Plan. From these events, members of the area Crisis Response Team will be identified to serve as the first responders to adolescent suicide attempts and completions. The teams will consist of school personnel, mental health workers, police, and family survivors.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

a. Last Year's Accomplishments

The percentage of very low birth weight (VLBW) infants continues a decreasing trend from calendar year 2000 to 2002 (from 2.4 to 2.1). The percentage of those born in facilities for high-risk deliveries increased from 83% in 2001, to 84.3% in 2002. The MCH Program continues to analyze areas in the state where VLBW babies are delivered in non-tertiary facilities, as indicated in the findings of the VLBW study finished in 2001. In that study, local patterns of service availability and delivery were an important modifiable factor for the site of delivery of the VLBW infants. In 2003, the Perinatal Commission drafted guidelines for neonatal care levels and determined, as an important change of the previous guidelines, that there should be a concordance in level between obstetrical and neonatal services (i.e. for a neonatal level III facility, obstetrical services should be of level III as well). It is expected that this change will determine that high-risk obstetrical patients will be delivered at facilities that will have adequate

neonatal level of care as well. The constant monitoring of these and other related factors is anticipated to have a positive effect on this measure over time.

Infrastructure Building Services
The Louisiana Office of Public Health (OPH) has constantly provided up-to-date data and information to the Louisiana Perinatal Commission who has been successful in establishing the framework for regionalization of perinatal services. Universal adoption of those standards will take several years, but it is expected that hospital licensing and Medicaid reimbursement requirements will become, with the new ruling, the main driving force towards its implementation. The MCH Director, as a member of the Perinatal Commission, and the MCH Epidemiologist, as a constant resource for data and information, have continuously served as consultants to the Commission regarding VLBW and other issues in MCH. In this setting, the MCH group participates in policy building and as facilitators in the ruling process.

During 2002-2003, the MCH program structured the Fetal and Infant Mortality Reduction Initiative as a statewide effort to support regional and local groups, with emphasis in community mobilization. As a result of this effort a proposal to implement a system that closely monitors of perinatal deaths, through regional Feto-Infant Mortality Reviews (FIMR), was presented to several regional groups. Most of the regions accepted the initiative and worked conforming the review groups and the community action teams to the technical assistance from the MCH Epidemiology group. This approach will have the advantage of timely, permanent, up-to-date information on fetal and infant deaths that will give immediate feed back to the community for potential interventions.

b. Current Activities

Infrastructure Building Services
The MCH program is aware of the difficulties of not having MCH epidemiologic support or dedicated MCH program development at the regional and local levels. The MCH program expanded an initiative on perinatal mortality reduction throughout the state that established regional programs addressing the topic. The lead MCH medical epidemiologist, together with the Maternity Medical Director, provides the coordination of this initiative. They engaged and promoted the creation of the regional groups participating in perinatal mortality reduction activities. These groups are funded by MCH. These nine grants promote community mobilization at the regional level and are coordinated locally by the FIMR/Perinatal Mortality Reduction Coordinator. During this fiscal year, grants were implemented in 5 out of the 9 regions. The remaining four groups are being established.

The MCH Epidemiology group provides the data to the regional groups and helps with the monitoring of the regional perinatal mortality reduction initiative. As a specific result of this initiative, we have three Fetal Infant Mortality Reviews (FIMRs) reviewing regional deaths with two more scheduled to begin reviewing in mid-2004. Local stakeholders and the MCH program have worked together in these regions to produce information on the reviewed deaths, including those related to VLBW infants. The review teams give recommendations to the established community action teams who will be in charge of finding ways and potential funds to implement the recommended preventive measures. Risk factor analysis from PRAMS and FIMR data will give better insight to prevent those deaths at all levels.

c. Plan for the Coming Year

Objective: Increase to 85.3% the proportion of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.

Infrastructure Building Services
The MCH grants for the perinatal mortality reduction initiative will continue to be supported by

the MCH Section throughout the state. Information for those groups will be provided regularly.

The MCH Epidemiology group will continue facilitating and providing the necessary technical assistance to the regional Fetal Infant Mortality Reviews (FIMRs). This support will continue and the reviews are expected to cover all the 9 regions in the state by September 2005. The MCH medical epidemiologist continues to assist these FIMR groups throughout the development of an autonomous system, which has allowed them to continue the reviews on their own.

The studies on risk factor analysis for this and other important health outcomes will continue to provide information for better insight into prevention of deaths of VLBW infants at all levels. This information will provide specific and detailed information on issues that may be addressed to prevent deaths on VLBW that might be associated with a birth in a non-level III facility. The availability of this information may result in better standardization of the management of this specific population of newborns.

Updates for the regional groups will occur and vital statistics analysis will continue to be performed.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

a. Last Year's Accomplishments

Early prenatal care has increased from 82.3% in 1998 to 83.8% in 2002. Louisiana has the highest percentage in the West South Central U.S. region and is 25th highest in the nation. (81.1% in 1997 to 83.2% in 2001).

Direct Services
Comprehensive prenatal care services were provided to 3553 pregnant women through 19,409 visits via the statewide network of parish health units. Nutritionists provided assessments and counseling to 10,088 pregnant women. Over 12,495 pregnancy tests were performed and 19,400 pregnant women obtained WIC benefits and health education from the parish health units. A prenatal clinic was added in New Orleans in collaboration with a primary care center located in a high-risk area. Contractors provided prenatal services to 1,026 low income women in New Orleans with approximately 8,103 visits.

Enabling Services
The Teen Advocacy Program in Baton Rouge served 122 pregnant or parenting teens. MCH funded an outreach/case management program in the NE region, which provided home visits, Medicaid application, health education, and referrals to 101 pregnant women. MCH assisted in funding Family Road of Greater Baton Rouge (a Healthy Start site), which provided services to 17,000 clients including prenatal classes, Medicaid eligibility screening, WIC, safety and parenting education, support groups for infant/child loss as well as battered women/rape crisis.

The Prenatal Risk Assessment tool, a self-report screening tool to identify women at risk for psychosocial issues was piloted in three parish health units. The tool was administered to over 130 women, initial results indicate the tool is appropriate.

Population-Based Services
The Partners for Healthy Babies social marketing campaign produced a new radio message in addition to implementing a statewide public relations plan that addressed the importance of

proper weight gain and nutrition during pregnancy. Two promotions emphasized early prenatal care and healthy behaviors, and nearly 10,000 teens attended the annual Teen Summit Event in New Orleans. The Helpline received 4188 calls in FY 2003. Extensive formative research was conducted in the summer of 2003 to assist with future project and message direction.

Infrastructure Building Services
Site evaluations and Patient Satisfaction Surveys were completed in all regions participating in prenatal services. All sites were found to provide adequate services; problematic issues were addressed through follow-up. Clients voiced appreciation for the ancillary services and helpfulness of staff. Wait time continues to be a problem. Training for MCH staff was based on the result of the previous year's needs assessment.
A 3-day workshop on MCH Epidemiology was held for the second time, addressing Perinatal mortality and introducing the Perinatal Mortality Reduction Initiative. More than 80 attendees (each region of state represented), build a diagnosis of their regional problems, and established a plan to address the identified problems.

b. Current Activities

Direct and Enabling Services
Direct and Enabling services outlined above are ongoing in order to continue the improvement of early access to prenatal care in Louisiana. Outreach, case management, and home visiting services have been initiated in 6 regionsSimilar interventions previously initiated in Shreveport, Alexandria, and Baton Rouge were continued or expanded.

Final revisions of the Prenatal Risk Assessment tool are being made and will be implemented in seven regions. Training for nurse and social work staff on usage/implementation of the tool along with appropriate actions to take based on findings is being developed .

Population-Based Services
The Partners for Healthy Babies project continues to employ a mix of communication strategies including multi-media advertising, (TV/Radio/Outdoor) educational materials (brochures, fliers, posters, newsletters) and group communication (speeches, health fairs, promotions). Planning for an improved Helpline (services and quality) along with repositioning and promotion of the Helpline as a one-stop-referral for women for all reproductive needs is underway. A comprehensive website is being developed.

Infrastructure Building Services
Quality assurance is conducted for each prenatal care site funded by the MCH Block Grant. The state maternity nursing consultants assure that training and quality improvement are conducted.

The Maternity Program Medical Director is serving to coordinate a state-wide Infant Mortality Reduction Initiative (IMRI)initiative will link state agencies, public providers and private providers to address and improve MCH outcomes. Each region has an identified Infant Mortality Reduction Coordinator. The Initiative has increased the number of regions with functional Fetal-Infant Mortality Review (FIMR) Boards, and is working on the implementation of Nurse-Family Partnership (NFP) programs in the identified highest needs areas of the state. The Medical Director is beginning a schedule of visiting each region of the state, supporting the community coalitions and providers within the region.

The Partners for Healthy Babies project works in coordination with the LaMOMS program, to assist in publicizing their program in outreach events. The LaMOMS program enrolled close to 4000 women in 2003 women enrolled in the new expansion eligibility category, who would not qualified for Medicaid coverage prior to expansion to 200% of the federal poverty level.

Technical assistance support from the CDC continues to facilitate the work of PRAMS. The PRAMS survey enables the MCH program to determine specific risk factors for prenatal and postnatal outcomes, and to develop appropriately targeted interventions through analyses performed by the team of MCH epidemiologists. This has turned the MCH program into a strongly evidence-based activity.

c. Plan for the Coming Year

Objective: Increase the proportion of infants born to pregnant women receiving prenatal care beginning in the first trimester to 84.2%.

Direct Services
Parishes in the lowest quartile for first trimester entry into prenatal care will be targeted for the development of prenatal initiatives.

Enabling Services
The MCH program will continue to assure that psychosocial issues are assessed during provision of prenatal services statewide by making the Prenatal Risk Assessment tool available in 6 parish health units, including East Baton Rouge, Terrebone, Lafayette, Desoto, Caddo, Rapides, Ouchita, and St. Tammany parishes. Trainings will be provided in order to complement the tool and the need for such psychosocial assessment as indicated and needed. These parishes were selected due to the availability of social support services from the Office of Mental Health (Early Childhood Supports and Services), Healthy Start, and MCH funded initiatives.

Population-Based Services
Partners for Healthy Babies will work in conjunction with the state maternity medical director to reach out to high risk areas of the state, including the private provider community and conduct extensive media messaging, public relations ,and other activities in these areas. Continued coordination is planned with the LaMOMS program to provide outreach to, and recruitment of pregnant women. Plans to restructure the Helpline services are also underway.

Infrastructure Building Services
The Louisiana Infant Mortality Reduction Initiative will be expanded with the Maternity Medical Director visiting regional coalitions, public providers, private providers and delivering hospitals throughout the state to further coordinate programs with the goal of improving access to early, quality care and improving MCH outcomes. FIMR panels will be established and review cases in all nine OPH regions of the state. Regional FIMR Community Action Teams will strengthen the community-based infrastructure to assess the problems associated with infant mortality, late prenatal care entry, and low birth weight. The community coalitions will develop ongoing needs assessments and organize community plans to address the needs, and monitor progress of the interventions implemented. Further collaboration with Partners for Healthy Babies will be developed targeting both patients and providers on the need for early entry into care.

MCH will continue to monitor quality assurance systems at all levels. The Site evaluation tool will be revised to address current program concerns.

Newly available 2002 PRAMS data is being analyzed and the final report will be widely distributed to stakeholders and will be made available through the Internet.

FIGURE 4A, NATIONAL PERFORMANCE MEASURES FROM THE ANNUAL REPORT YEAR SUMMARY SHEET

General Instructions/Notes:
List major activities for your performance measures and identify the level of service for these activities. Activity descriptions have a limit of 100 characters.

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
1) The percent of newborns who are screened and confirmed with condition(s) mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) who receive appropriate follow up as defined by their State.				
1. Universal newborn screening and follow-up conducted for 5 conditions.	☐	☐	☑	☐
2. Conduct training sessions at hospitals to reduce unsatisfactory screening specimens.	☐	☐	☐	☑
3. Conduct regional genetics clinics at 10 sites staffed by a medical geneticist.	☑	☐	☐	☐
4. Provide clinic-based wrap-around services by contracted sickle cell foundation staff.	☐	☑	☐	☐
5. Educate adolescent PKU girls and high risk maternity staff on fetal effects of maternal PKU.	☐	☑	☐	☑
6. Provide an educational program for sickle cell patients and families.	☐	☑	☐	☐
7. Provide an educational program for medical providers on metabolic diseases detected through tandem mass spectrometry.	☐	☐	☐	☑
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
2) The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)				
1. Employ Parent Liaisons in all CSHS offices.	☐	☑	☐	☐
2. Include parents in policy decision making at all levels.	☐	☐	☐	☑
3. Provide ongoing training for Parent Liaison staff.	☐	☐	☐	☑
4. Provide wrap-around services for all children in CSHS clinics.	☐	☑	☐	☐
5.	☐	☐	☐	☐
6.	☐	☐	☐	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB

3) The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)				
1. Regional Medical Home Programs.	☐	☐	☑	☐
2. Medical Home Learning Collaborative.	☐	☐	☐	☑
3. Screening and referral to primary care practices.	☐	☑	☐	☐
4. Work with Community Care and KidMed to facilitate primary care referral process.	☐	☐	☐	☑
5. Support transition services for adolescents.	☐	☑	☐	☐
6.	☐	☐	☐	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
4) The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)				
1. Collaborate with Medicaid and State Insurance Commissioner to assure coverage.	☐	☐	☐	☑
2. Inform families of available services and programs.	☐	☑	☐	☐
3. Provide informational materials to families in the clinical settings.	☐	☑	☐	☐
4. Work directly with families to link to services.	☐	☑	☐	☐
5.	☐	☐	☐	☐
6.	☐	☐	☐	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
5) Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)				
1. Assist families in accessing community-based services through Parent Liaisons.	☐	☑	☐	☐
2. Support CSHS community-based clinics in all regions of the state.	☑	☐	☐	☐
3. Provide workshops and support groups in community-based locations statewide.	☐	☑	☑	☑
4. Inform families about how to access community-based services.	☐	☑	☐	☐

5.	☐	☐	☐	☐
6.	☐	☐	☐	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
6) The percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life. (CSHCN Survey)				
1. Transition Task Force to draft and implement transition policies and procedures.	☐	☐	☐	☑
2. Education to adolescent and young adult clients and their families concerning transition.	☐	☑	☐	☐
3. Partnerships to provide transition information to adolescent clients and their families.	☐	☐	☐	☑
4. Screen all adolescents and young adults who are transition age.	☐	☑	☐	☐
5. Assist with the acquisition of services necessary to promote self-reliance and self-determination.	☐	☑	☐	☐
6.	☐	☐	☐	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
7) Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.				
1. Vaccines for Children (VFC) program supplies vaccines to enrolled providers.	☐	☐	☑	☐
2. Registry of birthing hospitals as VFC providers to offer 1st dose of Hep B free to all newborns.	☐	☐	☐	☑
3. Expansion of on-site VFC/AFIX (Assessment Feedback Information Exchange) active provider sites.	☐	☐	☐	☑
4. Louisiana Immunization Network for Kids Statewide (LINKS) database for providers.	☐	☐	☐	☑
5. Provide immunizations in public health units monitored by CASA reviews.	☑	☐	☑	☑
6. Collaboration with 11 statewide Infant Immunization Initiatives Coalitions.	☐	☐	☐	☑

7. Annual Shots for Tots Conference.	☐	☐	☐	☑
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
8) The rate of birth (per 1,000) for teenagers aged 15 through 17 years.				
1. Provision of comprehensive reproductive health care services to adolescents.	☑	☐	☐	☐
2. Presention and distribution of education materials to teens and professionals.	☐	☑	☑	☐
3. Technical assistance on teen pregnancy prevention mass media campaigns.	☐	☐	☑	☑
4. Training manual for clinic nurses to provide education on adolescent reproductive health issues.	☐	☐	☐	☑
5. Quality Assurance activities, including mystery calls to clinics.	☐	☐	☐	☑
6. Louisiana Teen Pregnancy Prevention Directory available online.	☐	☐	☑	☑
7. Training for clinics to create teen-friendly environment and increase teen utilization.	☐	☐	☐	☑
8. Contracts with local community-based organizations to conduct outreach to adolescents.	☐	☑	☑	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
9) Percent of third grade children who have received protective sealants on at least one permanent molar tooth.				
1. Provide LSUHSC School of Dentistry sealant program for children in select Orleans Parish Public Schools.	☑	☐	☐	☐
2. Provide LSUHSC Dental Hygiene sealant program for members of the Boys and Girls Clubs in Lafayette.	☑	☐	☐	☐
3. Development of a sealant model for statewide application in Louisiana.	☐	☐	☑	☑
4. Expansion of the sealant program through David Raines Health Center in Shreveport.	☐	☐	☐	☑
5. Expansion of the sealant program through the Helath Enrichment Network in Allen Parish	☑	☐	☐	☐
6. Identify and apply for outside sources of funding for the expansion of the sealant program into other areas of the state.	☐	☐	☑	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
10) The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.				
1. Provide Community Injury Prevention Coordinators in all nine regions of the state.	☐	☐	☑	☐
2. Participate in the Louisiana Passenger Safety Task Force (at the state and regional levels).	☐	☐	☐	☑
3. Provide child restraint technical assistance (checkup events).	☐	☐	☑	☐
4. Provide educational outreach through health fairs, seminars, and workshops.	☐	☐	☑	☐
5. Conduct child mortality data analysis.	☐	☐	☐	☑
6. Provide media outreach through newsletters and interviews.	☐	☐	☑	☐
7. Procure & distribute injury prevention resources such as car seats & educational materials.	☐	☐	☑	☑
8. Provice community outreach on child passenger safety through dissemination of educational material.	☐	☐	☑	☐
9. Support legislative activities that support injury prevention.	☐	☐	☐	☑
10.	☐	☐	☐	☐

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
11) Percentage of mothers who breastfeed their infants at hospital discharge.				
1. Provision of hospital grade and portable electric breast pumps.	☐	☑	☐	☐
2. Collection and analysis of WIC breastfeeding initiation and duration rates.	☐	☐	☐	☑
3. Implementation of breastfeeding policies and procedures.	☐	☐	☐	☑
4. Monitoring of positive clinic environment that endorses breastfeeding.	☐	☑	☐	☐
5. Establishment of Regional Breastfeeding Coalitions with inclusion of community organizations.	☐	☐	☑	☑
6. Provision of a 24-hour breastfeeding helpline.	☐	☐	☑	☐
7. Utilization of culturally appropriate breastfeeding educational videos, handouts, and posters.	☐	☑	☑	☐
8. Provision of breastfeeding classes for prenatal, postpartum and breastfeeding participants.	☐	☐	☐	☑
9. Provision of annual breastfeeding training for all clinic staff.	☐	☐	☐	☑
10. Provision of breastfeeding support and education materials for family members of breastfeeding clients.	☐	☐	☑	☑

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
12) Percentage of newborns who have been screened for hearing before hospital discharge.				
1. Improve data monitoring and tracking systems for Sound Start program.	☐	☐	☐	☑

2. Provide training on early hearing detection and intervention personnel.	☐	☐	☐	☑
3. Provide parent education, outreach and support.	☐	☑	☑	☐
4. Follow-up and tracking systems for children suspected of hearing loss.	☐	☐	☐	☑
5.	☐	☐	☐	☐
6.	☐	☐	☐	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
13) Percent of children without health insurance.				
1. Eligibility screening for Medicaid/LaCHIP for all infants, children, & pregnant women seen in OPH.	☐	☑	☐	☐
2. Provide Medicaid eligible clients with information on Medicaid and how to apply.	☐	☑	☐	☐
3. Technical assistance and support to Agenda for Children in their outreach efforts.	☐	☐	☑	☐
4. Technical assistance to the LACHIP and Medicaid Programs for outreach and enrollment.	☐	☐	☐	☑
5.	☐	☐	☐	☐
6.	☐	☐	☐	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
14) Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.				
1. Provide EPSDT screening services to Medicaid children who are seen in the OPH clinics.	☑	☐	☐	☐
2. Eligibility screening for Medicaid/LaCHIP for all infants, children, & pregnant women seen in OPH.	☐	☑	☐	☐
3. Provide Medicaid eligible clients with information on Medicaid and how to apply.	☐	☑	☐	☐
4. Work with local and regional public health staff to implement Community Care.	☐	☑	☐	☑
5. Complete Provider Capacity Needs Assessment.	☐	☐	☐	☑
6.	☐	☐	☐	☐
7.	☐	☐	☐	☐

8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
15) The percent of very low birth weight infants among all live births.				
1. Provide prenatal care for women with no health insurance coverage or access to private medical care	☑	☐	☐	☐
2. Provide nurse home visiting program (Nurse Family Partnership) for first-time mothers.	☐	☑	☐	☐
3. Provide Smoking cessation programs for pregnant women using the American Cancer Society?s Smoking Cessation model.	☐	☑	☐	☐
4. Support Partners for Healthy Babies public information campaign for prenatal health.	☐	☐	☑	☐
5. Provide Fetal and Infant Mortality Reduction Initiative in each region of Louisiana.	☐	☑	☐	☑
6. Provide Pregnancy Risk Assessment Monitoring System (PRAMS) surveillance system.	☐	☐	☐	☑
7. Support prevention of periodontal disease in pregnant women, through education and treatment.	☐	☑	☑	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
16) The rate (per 100,000) of suicide deaths among youths aged 15 through 19.				
1. School-Based Health Centers provide mental health counseling and referrals.	☑	☐	☐	☐
2. Coordination of Louisiana Youth Suicide Prevention Task Force.	☐	☐	☐	☑
3. Training of school, health and other community professionals on youth suicide prevention.	☐	☐	☐	☑
4. Facilitation and coordination of youth suicide awareness activities.	☐	☐	☑	☑
5. Participation in mandatory youth suicide prevention program in public schools.	☐	☐	☑	☑
6.	☐	☐	☐	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			

	DHC	ES	PBS	IB
17) Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.				
1. Study on regional distribution of VLBW infants born at all levels in the state, by region & parish.	☐	☐	☐	☑
2. Multivariate analysis of risk factors associated with mortality by hospital level and birth weight.	☐	☐	☐	☑
3. Survival analysis study by weight distribution and hospital level.	☐	☐	☐	☑
4. Annual update of the MCH Data Book.	☐	☐	☐	☑
5. Establish MCH grants for the perinatal mortality reduction initiative.	☐	☐	☐	☑
6. Development of the regional Feto Infant Mortality Reviews (FIMRs).	☐	☐	☐	☑
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
18) Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.				
1. Provision of prenatal services via network of parish health units and contract agencies.	☑	☐	☐	☐
2. Provide targeted case management programs, such as Nurse Family Partnership.	☐	☑	☐	☐
3. Link women to prenatal care via the Partners for Healthy Babies social marketing project Helpline.	☐	☐	☑	☐
4. Collect and analyze PRAMS data to provide program direction.	☐	☐	☐	☑
5. Provide Quality Assurance and program monitoring of all MCH funded prenatal services.	☐	☐	☐	☑
6. Develop Regional Infant Mortality Reduction infrastructure, at each regional level, using Coordinators.	☐	☐	☐	☑
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

D. STATE PERFORMANCE MEASURES

State Performance Measure 1: *Percent of all children and adolescents enrolled in public schools in Louisiana that have access to school-based health center services.*

a. Last Year's Accomplishments

The number of students with access to a school-based health center (SBHC) in Louisiana has increased from 4,600 to 48,494 students by the end of the 2002-03 school year. This represents 6.9% of the approximate 706,119 students enrolled in Louisiana public schools. There were 51 state-funded SBHCs and 1 federally funded SBHC, serving 85 schools (see

attached map). ASHI did not reach its goal of 7.4%. One SBHC closed because of financial constraints and 2 part-time sites became 1 full time site in 2002-03.

Direct Services
The State Legislature appropriated an additional $264,800 to expand services at existing SBHCs. In 2002-03, no new SBHCs were funded and the Rapides Foundation planned for a new SBHC. The SBHCs provide comprehensive primary and preventive physical and mental health services, including nurse case management for students with asthma. Nine SBHCs participated in laboratory testing for STDs and cervical cancer screening on site. SBHCs began screening high-risk students for type 2 diabetes. Of 1035 screens performed, 13 (1.3%) of tests were positive. All children with positive tests were referred for further evaluation and management.

Infrastructure Building Services
Nine SBHC sponsors underwent a rigorous on-site Continuous Quality Improvement (CQI) review. ASHI continued its Best Practices Initiative, coordinating educational workshops for SBHC staff based on clinical guidelines set by national experts. In 2002-03, the focus was the early detection of type 2 diabetes. Subsequently, data collected revealed that 13 of the 1035 students screened were positive for an elevated glucose. ASHI conducted a workshop on the prevention and management of obesity for SBHC personnel in August of 2003.

Forty-four of the 51 SBHCs are LaCHIP/Medicaid application centers. Through LaCHIP outreach efforts, SBHC staff decreased the % of uninsured students enrolled in SBHCs from 22% to 20%. ASHI hired a coding and billing expert to provide onsite technical assistance to enhance Medicaid revenues. Documentation of up-to-date immunization determined by random chart audits increased from 61% to 77% by the end of the school year. It is anticipated that this number will improve as more SBHCs enroll in OPH's LINKS, a computer-based system designed to consolidate immunization information among providers.

ASHI continues to work with the Department of Education (DOE) and other agencies and groups to promote coordinated school health. Through State Senate Concurrent Resolution 20, ASHI participated in a committee that reviewed current statutory and regulatory requirements for health screenings and procedures in all schools. Recommendations were submitted to the Board of Elementary and Secondary Education in February 2003 and to the State Senate and House Committee on Education during the 2003 Legislative Session. The 2nd annual Healthy Kids Day occurred in May 2003 with winners of the first annual Healthy School of the Year awards announced.

b. Current Activities

Direct Services
The ASHI Program continues to fund, provide technical assistance, and monitor the state-funded SBHCs. The Rapides Foundation funded SBHC opened this year. The SBHCs continue to screen students at risk for type 2 diabetes. MCH funding the on-site provision of STD screening, diagnosis and treatment, as well as cervical cancer screening at the SBHCs continues to expand with 19 SBHCs now participating.

Teams of professionals from 10 of the SBHCs are in the process of implementing Committed to Kids in SBHCs, a pediatric weight management program developed by experts from Louisiana State University Health Sciences Center. ASHI coordinated a training on this researched program in November of 2003. Data will be collected for evaluation purposes. A follow-up technical assistance videoconference is planned for April 2004.

Infrastructure Building Services
CommunityCARE, Louisiana's Medicaid managed care program, is now in all parishes as of

December 2003. It is based on primary care case management, linking Medicaid recipients with a primary care physician, Rural Health Center (RHC) or Federally Qualified Health Center (FQHC). ASHI has been successful in getting an exemption for SBHCs from CommunityCARE's primary care physician prior authorization requirement. SBHC Medicaid revenues would have been negatively impacted without this exemption. Now SBHCs will be able to continue to bill Medicaid, as they have in the past, for services provided to recipients 10 years and older. The process of enrolling centers as a "SBHC Medicaid Provider" type is still underway.

ASHI is collaborating with the Louisiana Primary Care Association and the Bureau of Primary Care and Rural Health to provide a technical assistance workshop on applying for 330 monies, which can be used to operate SBHCs.

Nine SBHCs will undergo an on-site CQI review in 2003-2004. ASHI has revised the CQI tool and will pilot it this spring. The new tool assesses the quality of clinical services and data management through core sentinel conditions and consists primarily of patient chart audits and data management assessment.

ASHI continues to collaborate with DOE, community-based organizations, and the Medicaid Program to develop strategies to increase school-based LaCHIP outreach.

c. Plan for the Coming Year

Objective: Maintain the percent of all children and adolescents enrolled in public schools in Louisiana that have access to school-based health centers at 6.9%.

Additional funding to plan and subsequently operate additional SBHCs was not allocated during the 2003 Louisiana Legislative Session as hoped. Consequently no new state-funded SBHCs will open in 2004-2005.

Direct Services
The ASHI Program will continue to fund, provide technical assistance, and monitor the state-funded SBHCs. Current services provided will continue to be available to students served by SBHCs. ASHI has requested additional funding from the State Legislature to plan eight new SBHCs in 2004-2005, which would become operational in 2006. The STD screening program will continue to be expanded.

Infrastructure Building Services
ASHI will implement the new outcome based CQI tool on SBHC site visits. ASHI will analysis evaluation data from sites participating in the Committed to Kids in SBHCs Program. ASHI will continue to collaborate with DOE and other agencies to promote and support coordinated school health programming.

State Performance Measure 2: *Percent of women in need of family planning services who have received such services.*

a. Last Year's Accomplishments

In 2003, 74,885 clients received comprehensive reproductive health care services through the Family Planning Program. This figure represents 23.8% of the estimated 314,000 women in need of family planning services in Louisiana. Seventy-five percent of these women were at 100% of the federal poverty level or below. Unplanned pregnancies are associated with higher rates of health problems for mother and baby. This relates closely to priority needs 1 and 5, which address infant mortality and morbidity, preterm births, and low birth weight; and access

and utilization of comprehensive health services for women of reproductive age, among others.

High quality health services require both sufficient and well-trained staff as well as systems for assuring quality. In 2002, the FPP was able to use Title X expansion funding to enhance staffing patterns in underserved areas of the state. Three advance practice nurses have been maintained in two regions with "high" or "very high" health professional shortages.

Direct Services
The OPH Family Planning Program receives supplemental funding from Title V and provides comprehensive medical, educational, nutritional, psychosocial, and reproductive health care services to women and men. Currently the Family Planning Program provides services in 69 state-administered facilities and 25 contract sites. Eleven of these sites provide services after 4:30pm on weekdays and/or on Saturday mornings.

Infrastructure Building Services
Ongoing training in new contraceptive methods as well as supportive services and client-centered care assured the quality of care provided in all parts of the state. Trainings were conducted on both regional and statewide levels and took advantage of opportunities to reach a large audience representing the range of health care providers.

Monitoring of most contract sites occurs at the regional level. Regional Medical Directors and other staff have been provided with the Clinical Contracts Monitoring Manual as well as additional training on conducting monitoring site visits. With turnover of contract sites, monitoring efforts take on added importance to ensure quality of services as well as to identify issues that need immediate remediation and to promote the longevity of the contract site. To this end, each region has submitted a schedule for contract monitoring site visits for the coming year. Based on this information, a master calendar has been created to facilitate follow-up from the central office.

b. Current Activities

Direct Services
The Family Planning Program (FPP) continues to provide comprehensive reproductive health care services to men and women.

Enabling Services
The Family Planning Program provides outreach to young men and women in the New Orleans and Baton Rouge areas through contracts with local community based organizations. A team of workers provides one-on-one and group reproductive health information to women and men in target areas of each city that includes referrals to Family Planning Program clinic sites. In the New Orleans area, young men and women under the age of 24 are the focus of the intervention. In Baton Rouge, Commercial Sex Workers in 3 zip code areas receive the outreach education.

Infrastructure Building Services
The Family Planning Program's Training Manager coordinated and or facilitated 27 training events from October 2003 to the present. Altogether, 1983 health professionals have been trained.

Monitoring of individual clinic sites, which occurs on a regional level, identifies areas that need remediation and improvement and the central office serves as a repository for all site visit reports. In this way, regional or statewide trends in service delivery can be assessed. It is the responsibility of FPP central office staff to ensure that all administrative and medical protocols are current and appropriate, and that all clinic sites have the resources to follow them. Both an annual, comprehensive review of the program manuals and an ongoing review of

developments in reproductive health will ensure that clinics are able to offer high quality services.

c. Plan for the Coming Year

Objective: Increase to 24% the proportion of women in need of family planning services who have received such services.

Direct Services
To increase the FPP's ability to serve the women in need of family planning services, at least 3 additional contract services sites will be added. In initiating contracts with family planning service providers, the FPP will attempt to identify providers who are able to provide services during evening and Saturday hours and at areas most in need.

Enabling Services
Through targeted outreach and education activities of the FPP Health Education and Outreach Manager and field and contract staff, the program will attempt to increase utilization of services by the women most in need. Specific activities focused on incarcerated women and commercial sex workers will include individual and small group reproductive health education, counseling and referral to services.

Infrastructure Building Services
The FPP relies on good quality data for federal reporting requirements as well as for program evaluation. In light of new agency-wide systems being installed for data collection, procedures for data verification on several levels are being developed to ensure completeness and accuracy of data at its source. Quality assessments will also be conducted to test these procedures.

The FPP plans to continue training activities on topics like emerging contraceptive technology, client-centered care, and clinic efficiency. These training activities will improve the quality of care while also increasing the program's capacity to provide services. Training activities are based on the findings of the annual statewide training needs assessment, as conducted by the FPP's Training Manager.

State Performance Measure 3: *The rate of children (per 1,000) under 18 who have been abused or neglected.*

a. Last Year's Accomplishments

The rate for FY 2003 of 7.8 cases/1000 children under 18 is significantly lower than the stated goal of 8.2 cases/1000 children. This rate reflects an unduplicated count of 10,744 children 0-18 years of age involved in 13,546 instances of validated abuse or neglect.

Direct Services
MCH clinics use a Child Health Record for children ages 0 to 6 that includes a psychosocial assessment of infants and children by parish health unit nurses. Parish health unit staff provides parent education, counseling, and educational materials for families. MCH has a joint agreement with the Office of Community Services to utilize local public health nurses to assist child protection workers in the investigation of families suspected of child abuse and neglect. During FY 2003, 78 children were assessed by public health nurses. Healthy Beginnings, an infant mental health program, provided early intervention services for over 100 infants and young children and their families.

Enabling Services

The 4 MCH-funded home visiting programs that follow the Healthy Families America (HFA) model to prevent child abuse and neglect served 295 families and made over 4,000 home visits in FY 2003. Four of these families were referred for child protection services; of these four, three families were served by a HFA program targeting women in a substance abuse treatment program.

The Nurse-Family Partnership (NFP) program added three new teams this fiscal year for a total of seven teams in 16 parishes. Between October 2002 and September 2003, 12,197 visits were made to 1078 families. Clinical trials and longitudinal studies have shown that this prevention model significantly reduces verified reports of child abuse and neglect.

Population-Based Services
Prevent Child Abuse Louisiana (PCAL) coordinated a statewide media campaign and speakers bureau addressing child abuse prevention. In 2003, 1223 calls were made to the helpline, 31% of which were stress/crisis calls.

Infrastructure Building Services
Seventy public health nurses and social workers, as well as social workers and case managers from the Office of Mental Health's Early Childhood Supports and Services (ECSS) received training in infant mental health (IMH). This 30-hour curriculum provides information and skills regarding early social-emotional development and parenting to improve identification of risk factors for child abuse and neglect.

The Child Death Review Panel(CDRP)facilitated 4 local panels' functioning across the state to review unexpected infant deaths and make recommendations for prevention of further deaths.

The Oral Health Program (OHP) published an article on child abuse and neglect in the Louisiana Dental Association Journal and reported on the number of abuse cases reported by dental professionals in the past year. OHP sponsored a 6-hour CE course on abuse and neglect at the New Orleans Dental Conference in September 2003. Dental professionals reported six abuse and/or neglect cases in 2003.

b. Current Activities

Direct Services
All programs and activities described for FY 2003 continue during this fiscal year as well. Healthy Beginnings served more than 60 new families from October 2003 through March 2004.

Enabling Services
Louisiana's Healthy Families program served over 340 low-income families. Out of these families, one family was reported by an anonymous source to the local child protection agency since October 2003. We are currently revamping the psychosocial services provided to pregnant women and their infants, and the new program will maintain strong attention to prevention of abuse and neglect through screening for risk, providing better access to basic services, and strengthening the parent-infant relationship.

The Nurse Family Partnership (NFP) now provides services in 19 of the 64 parishes of the state. Since the inception of the program through February 2004, the NFP has reached 1632 mothers and babies; of these, only five children under the age of 1 are known to have had validated neglect; there are no known incidences of physical abuse. A recent randomized-controlled study on NFP in one region of the state found that the majority of Emergency Room (ER) visits by NFP clients during the first year of life were due to illness versus injury (94% vs. 6%), with no ER visits reported for ingestions, suggesting that NFP recipients experience few significant injuries, likely reflecting safer home environments and better supervision by their caregivers.

Population-Based Services
This year the Prevent Child Abuse Louisiana helpline number was changed to 1-800-CHILDREN.

MCH is in the final stages of developing a new parent education newsletter, Happy and Healthy Kids. The newsletter focuses on social-emotional development and positive parenting from birth through 5 years. Distribution will begin in the fall of 2004.

Infrastructure Building Services
Since October 2003, over 55 public health nurses and social workers, including social workers from the EarlySteps (IDEA, Part C program) and case managers from OPH's ECSS program, received the 30-hour Infant Mental Health training. OPH co-sponsored Prevent Child Abuse Louisiana's Kids Are Worth It! Conference held March 2004 and was attended by nearly 400 professionals.

The Oral Health Program monitored and reported to dental professionals the number of abuse and neglect cases reported by dental professionals via state dental professional newsletters and journals.

The Child Death Review Panel facilitated 10 local panels' functioning across the state to review unexpected infant deaths and make recommendations for prevention of further deaths.

A training of Coroner's Offices and Death Scene Investigators is planned for the next year to improve death scene investigations for the determination of Sudden Infant Death Syndrome.

c. Plan for the Coming Year

Objective: To reduce the rate of children (per 1,000) under 18 who have been abused or neglected to 7.6.

Direct Services
The CDRP continues to facilitate and support local panels across the state to review unexpected child deaths. Recommendations from panels for prevention activities are developed and implemented in locally. A training is planned for OCS and OPH regarding the joint investigation of certain child abuse neglect cases by public health nurses during 2004.

Enabling Services
MCH will re-allocate funding for the Healthy Family America's (HFA) home visitation program into a new initiative that will provide screening, case management, psycho-educational support, limited individual counseling, and referral services in the current HFA communities. The goal is to continue to provide appropriate services for pregnant women and women with young children who have significant psychosocial risk factors that could impact maternal and child health or parenting. Training for the staff in these programs will be provided and monitoring will take place to assure program quality.

The NFP Program now exists in all 9 regions of the state, including 19 of the 64 parishes. The program plans to add additional parishes in the coming year.

Population-Based Services
MCH will continue to provide funding for PCAL to coordinate a statewide media campaign and speakers bureau addressing child abuse prevention. Their objectives for the next fiscal year are to maintain a high number of calls to the issues associated with child abuse, and to increase coordination and utilization of/among resources for parents statewide.

MCH will begin distribution of the new parenting newsletter series, Happy and Healthy Kids, to all new parents. This newsletter focuses on social-emotional development and positive parenting.

Infrastructure Building Services
Infant Mental Health trainings will continue to be offered throughout the state. OPH and OMH will develop a Memorandum of Understanding to ensure sustainability of infant mental health consultation services for the NFP program.

CDRP's plans for next year include: 1) continue to develop local panels; 2) develop an initial contact investigative report form for first responders to utilize in unexpected deaths of children under age 15; 3) conduct an assessment on the reporting of deaths to the panel in a timely manner; and 4) initiate prevention programs on statewide and local levels.

The SIDS Program continues to provide reimbursement for autopsies and death scene investigations for unexpected infant deaths. Autopsy and death scene investigations are necessary to rule out another cause of death such as suffocation, poisoning, or child abuse and thereby support the diagnosis of SIDS as the cause of death.

The OHP will continue to monitor the number of abuse and neglect cases reported by dental professionals. OHP will report this number in the Louisiana Dental Association Journal and the Louisiana Dental Hygienist Association Newsletter.

State Performance Measure 4: *Percent of CSHS patients with case management (follow-up visits) from a nurse, social worker, or nutritionist.*

a. Last Year's Accomplishments

According to PH-9 data, approximately 53% of CSHS patients received follow-up services from a CSHS nurse, social worker, or nutritionist during this period. This represents a slight increase over previous years.

Direct and Enabling Services
CSHS clinic staff in each of the state's nine regions provided follow-up to patients to implement the plan of care, facilitate linkages to needed services, as well as any other care coordination issues identified. Follow-up also included ensuring that the family was comfortable with what had been said to them during their visit to clinic and that the family acknowledged understanding. CSHS funded a care coordinator in one private pediatric practice as part of the Medical Home Learning Collaborative. This coordinator linked families to needed community resources, provided health education to children and families, coordinated services and provided follow-up and monitoring of the child's medical management plan.

Population Based Services
Nurses, social workers, and nutritionists in CSHS provided follow-up services to patients/families either by self-referral, physician referral, or through their own efforts (case finding). They continued to work to form relationships with families to build trust and confidence. They strived to provide services to all patients and their families in a compassionate, coordinated, culturally sensitive atmosphere. CSHS staff also provided information and referral to families of CSHCN who were not enrolled on the CSHS program and to the public when requested. Since spring 2003, CSHS has participated in the Medical Home Learning Collaborative national training sessions. These sessions enabled three private medical practices to initiate and improve all components of a medical home within their practices, including follow-up services for CSHCN.

Infrastructure Building Services
In May 2003 CSHS contracted with Louisiana State University to perform a Long Range Plan Needs Assessment to assist with program planning. Components of the plan focused on availability of health care providers that provide follow-up services for CSHCN. In addition, CSHS and Family Voices was granted a Medical Home Learning Collaborative grant in December 2002, which provided training and support to OPH staff and three pediatric primary health care practices in the state to set up model medical home practices. As a result of the Medical Home Learning Collaborative, these practices increased follow-up for children identified with a special health care need.

b. Current Activities

Direct and Enabling Services
Clinic staff in each of the state's nine regions continue to provide follow-up to patients to implement the plan of care, facilitate linkages to needed services, as well as any other care coordination issues identified. Follow-up also includes ensuring that the family is comfortable with what had been said to them during their visit to clinic and that the family acknowledges understanding. CSHS has also instituted a transition program for all adolescents age 14 who attend CSHS clinics. This program provides a formalized system of addressing issues for adolescents with special health care needs: staying healthy, safety, managing your own health care, being independent, emotional health, school & work and leisure activities. CSHS also provided an additional care coordinator for a second private pediatric practice. This coordinator linked families to needed community resources, provided health education to children and families, coordinated services and provided follow-up and monitoring of the child's medical management plan.

Population Based Services
Nurses, social workers, and nutritionists in CSHS continue to provide follow-up services to patients/families either by self-referral, physician referral, or through their own efforts (case finding). They continue to work to form relationships with families to build trust and confidence. They continue to provide services to all patients and their families in a compassionate, coordinated, culturally sensitive atmosphere.

Infrastructure Building Services
CSHS continues to implement the Long Range Plan Needs Assessment, which will provide information on availability of health care providers that can provide follow-up services for CSHCN. In addition, CSHS is working statewide to look at strategies to educate and inform health care providers on ways to implement medical home systems of care, including enhanced follow-up for CSHCN. CSHS has also contracted with a private provider to survey selected states Title V CSHCN programs, to obtain information about "best practices" for care coordination. Information obtained from this report will assist CSHS in developing policy and implementing practices to enhance care coordination activities provided by CSHS.

c. Plan for the Coming Year

Objective: The goal for the upcoming year is to increase to 57% the percentage of CSHS patients with follow-up from a nurse, social worker, or nutritionist.

Direct and Enabling Services
Clinic staff in each of the state's nine regions provided follow-up to patients to implement the plan of care, facilitate linkages to needed services, as well as any other care coordination issues identified. Follow-up also included ensuring that the family was comfortable with what had been said to them during their visit to clinic and that the family acknowledged understanding. Staff made sure that the family had been provided with all prescriptions, referrals, and necessary forms for any procedures that were needed. In addition, CSHS will

expand follow-up transition services in 2005 to serve children ages 14 & 15 who attend clinic. CSHS will also expand the Medical Home Learning Collaborative by adding a care coordinator in a third private pediatric practice.

Population Based Services
Nurses, social workers, and nutritionists in CSHS will continue to provide follow-up services to patients/families either by self-referral, physician referral, or through their own efforts (case finding). They will continue to work to form relationships with families to build trust and confidence. They will continue to provide services to all patients and their families in a compassionate, coordinated, culturally sensitive atmosphere.

Infrastructure Building Services
CSHS will begin to analyze preliminary data from the Long Range Plan Needs Assessment to develop information systems regarding the availability of health care providers that provide follow-up care for CSHCN. Based on the outcome of this study, decisions will be made concerning the future of the CSHS service delivery system and the method by which patients receive follow-up services. CSHS will also develop enhanced care coordination procedures for staff as a result of information gathered from other states "best practices" of care coordination for CSHCN.

State Performance Measure 5: *Percent of children (2-5) on WIC greater than or equal to the 95th percentile for BMI-for-age.*

a. Last Year's Accomplishments

The Louisiana National Pediatric Nutrition Surveillance System (PedNSS) indicates an upward trend in overweight children. Louisiana has 13.3% of children over the 95th percentile for BMI-for-age in 2003, while in 2002 the proportion was 13.5% as compared to the national PedNSS rate of 14.3%. The percent of overweight children has increased in Louisiana by 1.5% since 1997, compared to 1.8% nationally.

Direct Services: In the Office of Public Health (OPH), nutritionists, nurses, health educators and nutrition educators provide counseling and education sessions to families statewide on healthy eating and physical activity. During this period 28,390 families with children were provided counseling sessions. Referrals are made to WIC Services for specialized nutrition counseling.

Enabling Services: Louisiana utilizes the revised BMI-for-age growth charts for children which has provided at-risk children the opportunity for early identification on preventive interventions.

Two patient education cards were developed by MCH/WIC programs on childhood obesity and distributed to public health professionals: "Healthy Habits for a Healthy Weight" and "Active Play for a Healthy Weight". A series of 3 pamphlets called "Play With Me!" for infancy, toddler, and pre-schooler was developed in conjunction with a self-instructed module based on the Bright Futures in Practice: Physical Activity guidelines. The series and guidelines were presented at the statewide Nutrition Education Conference in July 2003 with over 200 nutritionists, nurses and nutrition education participating. Two nationally known speakers presented on effective nutrition counseling and physical activity. The "Play With Me!" pamphlets were also presented to public health professionals at the Southwest Regional USDA Satellite Video Conference April 3, 2003 on Childhood Obesity. Two videos were distributed to 164 public health clinics, with instructions on utilization with patients in classes or facilitative learning sessions.

Population-Based Services: The Kid's Activity Pyramid handouts were purchased and

distributed to approximately 800 members of the American Academy of Pediatrics, LA Chapter and to 164 public health clinics.

Infrastructure Building Services: Three written trainings on the Feeding Relationship have been developed: Feeding Relationship in Infancy, during Toddler Period and Pre-schoolers. These training guidelines were presented at the Nutrition Education Conference in July 2003.

MCH actively participates in the Louisiana Obesity Council, a council mandated by state legislation, composed of both public and private experts on the obesity issue. MCH actively participated in the development and implementation of the Southwest Regional USDA Satellite Video Conference 4/3/03 on Childhood Obesity which was telecast nationally to approximately 5,700 participants, with almost 500 from Louisiana.

b. Current Activities

Direct Services: Counseling and education sessions as well as referrals to WIC continue to be provided as previously described.

Enabling Services: A positive feeding relationship is essential for a child's proper nutrition and growth. To address the feeding relationship, 3 pamphlets entitled "Mealtime Magic" will be developed and presented at the statewide Nutrition Education Conference in July 2004.

As follow-up on the information from last year's Nutrition Education Conference in July 2003, site visits have been conducted in several regions of the state to support and promote effective nutrition counseling through facilitative learning sessions and the "Play With Me!" series and guidelines. On-going support to public health providers is provided to promote quality patient education.

Infrastructure Building Services: To continue to incorporate childhood obesity education into nutrition education statewide, a facilitative nutrition session for patients will be developed that focuses on the feeding relationship between parents and their children. This session will include the division of responsibilities of parents and children. This will be presented at the statewide Nutrition Education Conference in July 2004 and follow-up will be conducted statewide for support and implementation.

c. Plan for the Coming Year

Objective: Reduce the proportion of children on WIC age 2-5 that are overweight to 13.2%.

Direct Services
MCH will continue to provide services in OPH for counseling and education sessions to families statewide on healthy eating and physical activity. Referrals to WIC Services for specialized nutrition counseling will continue.

Enabling Services
MCH actively participates in the Southwest Regional USDA committee to address childhood obesity. To promote the information and practices presented at the Satellite Video Conference April 3, 2003 on Childhood Obesity, the committee will develop training modules for health professionals and tabletop message modules for patient education. Included in these modules will be: becoming a person of influence, healthy feeding for a healthy weight, physical activity, and television time. Distribution and training of these modules will be implemented throughout the state.

Infrastructure Building Services
MCH will continue to actively participate in the Louisiana Obesity Council and the Southwest

Regional USDA committee.

State Performance Measure 6: *Percent of women who have had a baby who report physical abuse either during their last pregnancy or in the 12 months prior to becoming pregnant.*

a. Last Year's Accomplishments

Data from the Louisiana Pregnancy Risk Assessment Monitoring System (LaPRAMS) show that the number of women surveyed, who reported physical abuse during or in the last 12 months before their most recent pregnancy, may be growing. This data was first collected in 1997, and showed a rate of 10.5%, followed by 10.6% in 1998. A drop to 9.5% in 1999 has been followed by small increases for the following two years, with 10.1% in 2000, and 11.2% in 2001, the most current data available. While this absolute increase in percentages reported is not statistically significant, we will continue to monitor carefully these data.

Direct Services
The OPH Child Health Record includes risk factors associated with child abuse and neglect, including domestic violence. This record, used when an infant or child is served by the health unit for child health, provides a potential screen for exposure to violence. Based on initial analyses, 2.5% of respondents acknowledged exposure to violence either in their home or community.

Enabling Services

The Nurse-Family Partnership (NFP) expanded to 3 additional regions during this time period. Nurse visitors conduct regular assessments for the presence of physical and sexual abuse of the client; if identified, nurses provide support, make appropriate referrals, and provide ongoing case management. A recent study on the NFP program in Louisiana, completed by Dr. Neil Boris and colleagues at Tulane School of Public Health and Tropical Medicine in 2003, found that 18% of all women enrolled in the study were victims of partner violence, and 21% were perpetrators of violence while pregnant. However, those in the NFP program reported a 9% decrease in victimization, and a 27% decrease in perpetrating violence within 6 months after delivery.

The Louisiana Prenatal Risk Assessment tool which included questions about domestic violence, was successfully piloted in 2 clinics in New Orleans with over 100 pregnant women completing the one-page self-administered questionnaire.

Population-Based Services
Domestic violence emergency referral/safety cards specific to each region of the state were updated and distributed to all parish health units, State Office of Public Health women's restrooms and to private providers. These cards provide a list of necessities to take when a woman leaves, local resources, and phone numbers for the National Domestic Violence Hotline.

Infrastructure Building Services
The PRAMS survey enables MCH to determine prenatal and postnatal risk behaviors, and to develop appropriately targeted interventions.

b. Current Activities

Enabling Services

The Louisiana Prenatal Risk Assessment form is undergoing final revisions, and data collection and training approaches for use of the form are being developed. When clients are identified as having risk factors, appropriate follow-up and/or referral is arranged.

Population-Based Services
The domestic violence emergency referral/safety cards have been updated to assure accurate referral contact information and they continue to be distributed throughout the state.

c. Plan for the Coming Year

Objective: Reduce to 9.5% the proportion of women who have had a baby who report physical abuse either during their last pregnancy or in the 12 months prior to becoming pregnant.

Enabling Services
The Prenatal Risk Assessment tool, described above, will be implemented in 4-6 Louisiana public health units. The majority of the health units do not provide direct clinical services for maternity patients, but they all provide pregnancy testing and WIC services. Public Health Nurses can readily implement the assessment tool, identify clients at risk, and make necessary referrals. In addition, we will be piloting a program that will provide case management (for basic needs), psycho-educational support, and more intensive treatment or referral services in these parishes. The Prenatal Risk Assessment will serve as one "point of entry" into this prevention/early intervention service. If the woman would benefit receiving more intensive mental health counseling or other referrals, the RN can refer her for appropriate interventions, including Office of Mental Health's new Early Childhood Supports and Services program (ECSS), which serves infants and young children under five and their families who are at risk for serious social, emotional, or behavioral problems. ECSS is currently implemented in six Louisiana parishes, some of which overlap with the new OPH initiative described above. Rates of reported domestic violence, and referrals made, will be tracked through the screening procedures.

The NFP program will continue to address domestic violence during pregnancy, and provide education, counseling and referrals for women in need of these services.

Population-Based Services
The domestic violence emergency referral/safety cards will be updated and distributed annually, with emphasis on distribution to private providers. In addition, a Spanish version of the card will be developed and distributed to locales with significant Spanish-speaking only communities. A Health Education Coordinator will be hired and will provide oversight and monitoring regarding the distribution and use of the domestic violence referral/safety cards.

Infrastructure Building Services
PRAMS data for 2002 will be available in the fall of 2004 for analysis. A trend analysis will be performed to determine why the reported rates of domestic violence have increased over the past 3 years, which will be used to determine intervention approaches for this problem.

In addition, an MCH Task Force on Domestic Violence will be convened to review, monitor, coordinate, and if necessary, recommend or develop new strategies for addressing domestic violence in the maternal-child population.

State Performance Measure 7: *Percent of women who use substances (alcohol and tobacco) during pregnancy.*

a. Last Year's Accomplishments

Louisiana Pregnancy Risk Assessment Monitoring System (PRAMS) data for 2001 indicates that 13.4% of all pregnant women reported drinking and/or smoking during the last three months of their pregnancy, down from 16.1% in FY 2000. Substance abuse during pregnancy contributes significantly to low birth weight, infant morbidity and mortality.

Direct Services
MCH continued funding of the Perinatal Enrichment Program (PEP) at Medical Center of Louisiana at New Orleans (MCLNO). PEP provides behavioral health services such as substance abuse treatment, child developmental assessment and early intervention, mental health screening, and family support to drug-affected families. Women in the MCLNO prenatal clinic and those entering the perinatal inpatient unit are screened and assessed, as indicated. Those with moderate and severe problems with drugs and/or alcohol are counseled and encouraged to enroll in PEP. PEP enrolled 140 prenatal and postnatal patients during FY 2003.

Enabling Services
The Nurse-Family Partnership (NFP) works to improve women's health behaviors during pregnancy, including prevention of substance use. Nurse visitors provide health education, referrals, case management, and other support to pregnant women. The randomized controlled study of the Nurse-Family Partnership issued findings in March 2003, indicating that women who received nurse-visitor services were less likely to drink, especially heavily. The results show a 17% reduction in any alcohol use, and a 51% reduction in alcohol use to intoxication. Additionally, the study indicates a 25% reduction in cigarettes smoked by the end of the pregnancy for those women who received a nurse-visitor.

The MCH office continued its collaboration with the Office of Addictive Disorders (OAD), offering voluntary pregnancy testing to women admitted to OAD substance abuse rehabilitation and treatment centers. A total of 940 pregnancy tests were performed statewide in FY 2003. A total of 49 tests were found to be positive, consistent with the statewide percentage that tested positive in prior years in the program.

Gaps in smoking cessation services for perinatal populations were addressed through a contract with the American Cancer Society (ACS). ACS trained 1000 public and 31 private providers in Make Yours a Fresh Start Family (MYFSF), a comprehensive smoking cessation program for perinatal populations. The intervention consisted of initial screening, complete assessment, counseling/educational sessions with prenatal clients found to be tobacco users, and follow-up at all subsequent visits. MYFSF screened approximately 3,750 pregnant women, counseled 850 pregnant smokers, with a 5% smoking cessation success rate due to program intervention.

Population-Based Services
The Louisiana Coalition for MCH continued to oversee and manage the MCH funded Louisiana Perinatal Substance Abuse Clearinghouse of educational materials on alcohol, tobacco, and other drug use during pregnancy.

b. Current Activities

Direct and Enabling Services
MCH continues to maintain the PEP contract. There are 39 clients actively enrolled and receiving treatment and other services. PEP, through collaboration with other social agencies and programs, provides transportation assistance and referrals to clients for treatment and rehabilitative services.

MCH is in a collaborative agreement with the Office of Addictive Disorders to offer substance abuse services for women in the northeast region of the state. Prenatal clients are screened,

provided brief intervention services, and assessed to determine their need for substance abuse treatment and services. Since the inception of services in January 2004, 189 clients were screened and received brief intervention, 3 were assessed, and 3 are currently receiving treatment.

A Prenatal Risk Assessment tool has been instituted in two regions. The tool screens women receiving maternity services in Office of Public Health (OPH) clinics, addressing tobacco, alcohol, and other drug use.

The contract with the American Cancer Society continues training providers in the 10 parishes of the state identified as highest priority. Since October 2003, the Make Yours a Fresh Start Family program screened approximately 2,800 pregnant women, counseled 650 pregnant smokers, with a 5.6% smoking cessation success rate due to program intervention.

Population-Based Services
The Perinatal Substance Abuse Clearinghouse continues to provide educational materials on alcohol, tobacco, and other drug use during pregnancy for distribution to private providers, health units, and schools.

Infrastructure Building Services
The Maternity Program evaluation is ongoing through the Quality Assurance (QA) program. Program medical and nurse consultants update maternity clinical protocols and manuals annually. QA performance measures continue to be monitored by the State Nurse Consultants. Assessing prenatal patients for alcohol and tobacco is part of the protocol and history section of the medical record.

MCH, in conjunction with Family Planning and Sexually Transmitted Disease (STD), sponsors a statewide Women's Health Training series, held every fifth Friday of the year to address maternal, family planning and STD issues. State and contract providers are invited and encouraged to participate. CE and CME credits are provided to eligible participants. There were a total of 386 participants in October 2003 and January 2004. The clinical nurse specialist from PEP presented Perinatal Substance Abuse from the PEP Program during the October training session.

c. Plan for the Coming Year

Objective: Reduce the percent of women who use substances (alcohol and tobacco) during pregnancy to 13.0%.

Direct Services
The Perinatal Enrichment Program (PEP) plans to meet its capacity of clients served by serving 40 women and 80 children.

MCH's collaboration with Office of Addictive Disorders in the PEP and Monroe Pilot Program allows more treatment and supportive services for the perinatal substance abusers in two regions of the state.

Enabling Services
The contract with the American Cancer Society will continue to maintain relationships with trained facilities and providers through site visits and monthly reports from these facilities. Efforts this year will continue to focus upon recruitment in the private sector. Both process and outcome evaluation of the program will be conducted.

The NFP program will continue to address substance abuse during pregnancy, and provide education, counseling and referrals for women in need of these services.

Population-Based Services
A program specialist will provide coordination, management and evaluation of statewide MCH health promotion activities surrounding perinatal substance abuse and smoking cessation. Activities will include monitoring development of media campaign activities related to substance abuse and promotion and maintenance and evaluation of substance abuse related health education materials.

Infrastructure Building Services
MCH will continue to monitor quality assurance activities at all levels. Continued statewide maternal health videoconferences are planned. A Prenatal Risk Assessment tool will continue to be used to screen women receiving maternity services in OPH clinics, addressing tobacco, alcohol, and other drug use.

State Performance Measure 8: *SPM-11: Rate of infant deaths due to Sudden Infant Death Syndrome.(SPM-08: DISCONTINUED in 2004. Percent of infant deaths due to SIDS that have a complete autopsy and death scene investigation)*

a. Last Year's Accomplishments

Over the years the overall SIDS death rate per 1,000 live births has decreased from 1.3 in 1998 to 1.0 in 2001. The racial disparity between Blacks and Whites has also decreased from 2.3 in 1997 to 1.5 in 2001. PRAMS data indicate that back sleeping has increased from 32% in 1997 to 41% in 2001. The autopsy and Death Scene Investigations (DSI) are essential elements for making a diagnosis of SIDS. In 2002, 100% of SIDS cases received an autopsy, and 22 or approximately 32% of infant deaths due to SIDS had both a DSI and autopsy, a decrease from 59% in 2001. The decrease in the number of SIDS deaths with DSIs indicate a need for more SIDS program protocol training for all coroner investigators and reassessment of coroner notification system of probable SIDS to OPH.

Direct and Enabling Services
The SIDS Program coordinated with Children's Bureau to provide grief counseling for families of SIDS victims and ongoing support through a SIDS support group in the New Orleans area. For calendar year 2003, Children's Bureau served 28 families in the New Orleans area with counseling and support to families of infant deaths not diagnosed as SIDS. The OPH provided counseling to 12 families in the rest of the state.

Population-Based Services
A social marketing public information campaign about safe sleep environment promotion was implemented within high-risk target population areas of the state through the media, community outreach, and medical profession outreach. Educational SIDS posters and videos were developed and distributed statewide to birthing hospitals, healthcare and daycare providers. The SIDS Program continued collaboration with existing community-based organizations to disseminate the message. Educational efforts targeted social workers, emergency medical staff, police officers, and medical examiners statewide.

Infrastructure Building Services
The MCH Program contracts with Tulane University School of Medicine, Pediatric Pulmonary Section, for the position of SIDS Medical Director. This has allowed improved capacity to identify, counsel and follow-up with families of SIDS infants, as well as improved monitoring of the overall program. A SIDS Program Coordinator works to establish community-based education on SIDS risk reduction in areas with infants who are at high risk of death due to SIDS. MCH provided SIDS-related education programs to public health nurses, coroners, law enforcement, social workers and the general public. The SIDS Program provided a statewide

educational teleconference on safe sleep environment promotion in March of 2003 to Public Health professionals.

The Louisiana Child Death Review Panel (CDRP) reviewed all unexpected deaths in children under age 15, including all SIDS deaths. The SIDS Program also distributed a birthing hospital survey about newborn nursery sleep position policy and newborn hospital discharge counseling to target interventions and educational efforts for medical professionals.

b. Current Activities

Direct and Enabling
The SIDS Program continues to coordinate with Children's Bureau to provide grief counseling for families of SIDS victims and the formation of a SIDS support group in the New Orleans area. Children's Bureau has also developed a network of parent peer contacts/community health educators to provide additional counseling and resources for families who are victims of SIDS.

Population-Based Services
The social marketing public information campaign about safe sleep environment promotion continues within high-risk target population areas through the media, community outreach and medical profession outreach. Current activities include continued development of educational materials, evaluation of media messages and educational materials, and monitoring and tracking of SIDS media placement statewide.

Infrastructure Building Services
The SIDS Program continues collaboration with existing community-based agencies and organizations including family day care/child care providers, senior citizen organizations, and the faith-based community in dissemination of the risk reduction message. Faith community kits continue to be distributed statewide. SIDS program educational efforts continue to target social workers, emergency medical staff, police officers, and medical examiners statewide. A train-the-trainer manual for safe sleep environment promotion for childcare providers was developed. Currently the SIDS Medical Director reviews autopsy and death scene investigations. Death scene investigative report forms were revised and distributed to coroner offices. Based upon feedback from coroner's offices statewide, MCH is reviewing and revising the length of the coroner investigative form. In addition, coroner notification protocols of probable SIDS deaths to public health have been revised. Coroner offices now report probable SIDS deaths to OPH regional offices, which promote and foster local relationships with coroner's offices and timely follow-up by OPH regional offices for bereavements services to families. Analysis of data obtained through death scene investigation reports is expanding to provide improved information about the relationship between the risk factors and unexpected infant death. The CDRP reviews all unexpected deaths in children under 15, including all SIDS deaths.

The SIDS Program is also utilizing data from the birthing hospital survey about newborn nursery sleep position policy and newborn hospital discharge counseling to target interventions and educational efforts for medical professionals, including the dissemination of a discharge teaching tool for hospitals to utilize.

The SIDS Program has been working with the MCH Perinatal Mortality Reduction Initiative by provided information and training on SIDS risk reduction to the Fetal Infant Mortality Review (FIMR) medical review and community action teams.

c. Plan for the Coming Year

Objective: Decrease to 0.7 per 1,000 live births the number of infant deaths due to Sudden

Infant Death Syndrome.

Direct and Enabling Services
In addition to providing grief counseling for families of SIDS and ongoing support through the SIDS support group, Children's Bureau plans to continue the network of parent peer contacts/community health educators to provide additional counseling and resources for families who are victims of SIDS. The OPH will continue to provide bereavement support to SIDS families in the rest of the state.

Population-Based Services
The social marketing public information campaign about safe sleep environment promotion will continue to be implemented within high-risk target population areas of the state through the media, community outreach and medical profession outreach. Evaluation of media messages and materials will be performed through formative research.

Infrastructure Building Services
The SIDS Program will continue interagency collaboration with existing community-based agencies and organizations in promotion of safe sleep environment messages. The SIDS Program plans to develop a comprehensive statewide plan to promote SIDS risk reduction and safe sleep environment.

Autopsy and death scene investigations will continue to be reviewed by the SIDS Medical Director. The SIDS Program plans to provide death scene investigation training for coroner investigators and produce a downloadable investigation form for coroner's investigators to promote efficient submittal of investigative forms to OPH. Child Death Review Panel will continue reviewing SIDS deaths as well. Special reports on infant mortality will be provided to the State Commission on Perinatal Care and Infant Mortality, SIDS Steering Committee, and other interested groups.

State Performance Measure 9: *Percent of Central Office and regional epidemiologic positions filled and working on MCH/CSHS data and epidemiologic issues.*

a. Last Year's Accomplishments

In 2003, 95% of the MCH epidemiology positions were filled: one CDC senior MCH epidemiologist, 4 MCH program, 3 CSHS, 2 PRAMS and 8 regional epidemiologists. The agency still maintains the memorandum of agreement with the CDC to keep the MCH senior epidemiologist as an MCH CDC Assignee. The number of staff partially dedicated to MCH epidemiology has also increased at the regional level.

Infrastructure Building Services
The MCH Epidemiology Assessment & Evaluation (EAE) team supports the regional programs for the analysis of perinatal mortality. Vital records data is provided in the form of the MCH Data Book. During 2003, the MCH Data Book was updated to include data from 1990 to 2000. The EAE group determines statewide priorities based upon analysis of vital records and PRAMS (Pregnancy Risk Assessment Monitoring System) data. MCH also supported regional groups working on Feto-Infant Mortality Review (FIMR) programs within 5 regions with 3 regions starting reviews and 2 in development. Plans to include the remaining 4 regions are already in progress. Epidemiological analyses and data have been crucial for the development of the FIMR groups and the initiatives.

Another major initiative is the linkage to other databases of statistics on maternal, infant and child health; census information; and health service utilization. The Child Death Review, which is staffed by MCH, continues its reviews of unexpected infant and children deaths. The oral

health needs assessment and data from PRAMS for the Oral Health program was analyzed. Medicaid has approved periodontal disease treatment for pregnant women. The MCH Epidemiology group is the lead group in charge of the monitoring and economic analysis of this new program.

MCH EAE produced special reports on the status of perinatal mortality by administrative region and by some parishes. Other special reports were produced on breastfeeding, oral health, SIDS, mortality by level of hospital, and maternal mortality. MCH EAE also produced a report for the State Commission on Perinatal Care and Infant Mortality. Specific data for the Healthy Start federal grant applications was provided to the 3 programs in state. Data produced by the MCH EAE team has been used to assist in planning and policy development throughout the state and as a result, the group organized a statewide meeting to address fetal and infant mortality. The meeting was held in November 2002, with the regions represented by working groups. The participants worked for one and a half days studying their regional and state data for several indicators related to perinatal death. Each group had an epidemiologist from the MCH section and a regional epidemiologist working to evaluate problems and potential interventions. The regional groups developed an evidence-based two-year plan for MCH supported by the data reviewed. The report produced at the meeting has been used for planning and helping in the distribution of MCH resources.

b. Current Activities

Infrastructure Building Services
The MCH Epidemiology program continues a very active inter- and intra-regional collaboration with the existing regional groups working on perinatal mortality and FIMR. The Fetal-Infant Mortality Reduction Initiative Coordinator works with the regional teams to coordinate these efforts. The LaPRAMS program finished its sixth year of data collection in November of 2003 and finished its fifth annual PRAMS report. The MCH Epidemiology program continues to develop specific ways to educate program and non-epidemiology people into MCH Epidemiology and supports all programs and regional teams and continues to provide funds for specific training in MCH Epidemiology for MCH, regional and program (BRFSS epidemiologist, Injury and Lead Poisoning Prevention Programs).

The MCH Data book was distributed and the first update was completed (2000-2002) this year. The update was distributed at the second MCH Meeting in November of 2003. The book and the update, which contain the most relevant information on important MCH indicators by region and parish, were used to train regional staff (Regional Medical Directors, Regional Nurses, Regional Epidemiologists, Healthy Start Directors and their delegates, and other invited personnel) on evaluation techniques. The meeting provided preliminary training activity preceding the Title V MCH Needs Assessment started this year. In order to facilitate the meeting, a group of nationally recognized researchers and evaluators from the University of Alabama School of Public Health, the CDC in Atlanta, and the University of South Florida, were invited. They were able to work with the regional groups on theory and exercises related to evaluation and need assessment. The MCH Data Book provided the core of the data analyzed. The book has enabled state's regions to evaluate their MCH status and request more detailed data for the planning of services and elaboration of grant applications. The MCH Data Book will be updated yearly.

The program continues to provide assessment and technical assistance to all MCH programs and enterprises throughout the state. Program evaluation has been one of the newest components and it has been required on every new grant that the MCH program has awarded. The MCH Epidemiology program is currently planning the third statewide conference on perinatal mortality for November 2003. The specific topic for this year's conference will be the MCH Needs Assessment. Speakers and facilitators have already been contacted.

c. Plan for the Coming Year

Objective: Maintain at 95% the proportion of MCH epidemiology positions filled.

Infrastructure Building Services
The State Epidemiologist and the MCH program have filled all the positions that were open for MCH and regional epidemiologists. As a result, the positions are full and activities have been developed to provide a working environment that will secure those already recruited. Analytical work on MCH data will continue for current and developing MCH programs. The MCH program in the Louisiana Office of Public Health was awarded a HRSA-CDC ORISE MCH fellowship. MCH submitted the application for the continuation of the fellow for the next year. This continuation is to start in June 2004.

For the incoming year (2004-2005) the MCH Epidemiology program will work on several well-defined aspects:

1. Continue the programmatic analysis of vital records data to provide evidence for the different programs throughout the state.

2. Continue working on PRAMS as the main source of risk behavior data in the state from the perspective of MCH.

3. Organize the Annual Fetal and Infant Mortality Meeting in November 2004. This meeting is expected to surpass the 100 invitees level. The main topic will be needs assessment and strategic plans for regional infant mortality reduction.

4. Continue to support the training of MCH dedicated epidemiologists through programs developed with the Universities, CDC, ORISE, GSIP, etc.

5. Present at least 8 different research topics at the National MCHEP conference in Atlanta.

6. Select some of these research topics for further publication and dissemination in different media.

7. Continue supporting the Feto Infant Mortality reduction Initiative and the FIMRs in the regions.

8. Continue with the Title V Needs Assessment.

9. Conduct a two-day workshop on evaluation at a national meeting.

State Performance Measure 10: *Percent of licensed day care centers with a health consultant contact.*

a. Last Year's Accomplishments

There are 160 regional Child Care Health Consultants (CCHCs). Approximately 97% of these are registered nurses, while the remaining 3% are nutritionists, physicians and social workers. A total of 1,039 child care centers utilized the training services of a CCHC during 2003 representing 52.2% of all centers in Louisiana, indicates the highest percentage since 1999.

Infrastructure Building Services
The CCHC Program collaborated with agencies responsible for child care issues, including the

Department of Social Services (DSS), the state agency with primary responsibility for planning, overseeing and regulating child care services. DSS administers the subsidy program that helps low income families pay for child care. To participate in this program, family day homes register with the DSS program. The CCHC Program collaborated with the Division of Environmental Services to incorporate into the State Sanitary code that each child care provider shall receive three hours of training each year on health and safety issues by an approved CCHC. DSS, Bureau of Licensing require child care providers working in family day homes and child care centers to obtain 15 hours of training which three of these hours should be the Sanitary Code required health & safety training. Child care providers working in family child care homes must meet this annual requirement to maintain their registration with DSS, while those working in child care centers must meet this annual requirement to maintain licensure.

CCHCs provided 4,985 hours of training and 206 hours of technical assistance to 14,072 child care providers. CCHCs provided 339 hours of training on medication administration to child care providers and 95 telephone consultations and 16 reviews of child care health policies and procedures. The training topics most frequently offered were infection/disease control and chronic disease/illness, followed by medication administration, illness in child care and food safety.

The CCHC Program Director coordinated the CCHC Quality Assurance Committee and the CCHC Statewide Interagency Advisory Committee, which met 4 and 2 times during FY 2003 respectively. The Quality Assurance committee works with the Program Director to monitor CCHC activities, adherence to standards, and plan CCHC Training Conferences. The Statewide Interagency Advisory Committee is made up of multi-disciplinary professionals who serve in an advisory capacity to the program.

A list of the 28 CCHCs that have expertise in serving children with special health care needs is maintained and provided to centers needing this support and technical assistance.

The CCHC Program implemented a statewide training for CCHC on September 17 -- 19, 2003 that featured topics related to standards from the National Health and Safety Performance Standards: Guidelines for Out-of-Home Child Care Programs and utilized the curriculum from the National Training Institute as a model to develop the agenda.

b. Current Activities

Infrastructure Building Services
The CCHC Program continues to collaborate with agencies that are responsible for child care issues in the state. Representatives from these agencies serve on the Statewide Interagency Advisory Committee, which met in February and March 2004.

In an effort to facilitate training opportunities and technical assistance on health & safety issues, the CCHC Program contracts with Resource & Referral (R&R) Agencies in Louisiana. The R&R Agencies provide information to parents about available child care centers and family child care homes. They also provide technical assistance and training to child care providers and are instrumental in promoting referrals to CCHCs. Efforts to increase utilization of CCHCs by child care providers are ongoing. The DSS Bureau of Licensing includes a brochure that promotes CCHCs in their licensing renewal notices to all child care centers statewide.

Two statewide trainings for CCHC are scheduled for May and September 2004. CCHCs provide trainings to child care providers on health and safety issues. CCHCs also provide trainings on the new medication administration policy in an effort to decrease medication errors in child care centers.

The medication administration policy is in the revised November 1, 2003 Child Care Licensing Regulations and specifies that child care providers who administer medications in facilities, must have 3 to 4 hours of training from a CCHC in addition to the existing 3 hours health and safety training.

c. Plan for the Coming Year

Objective: Increase to 57% the proportion of licensed day care centers with a health consultant contact.

Infrastructure Building Services
A current database of all CCHCs will be maintained. Updates will be forwarded to Resource and Referral Agencies, the Quality Assurance Committee, the Statewide Interagency Advisory Committee and other interested persons. A database of potential candidates who wish to become CCHCs will be maintained. Satisfaction surveys will be conducted to identify the needs of consultants and concerns of child care providers.

Training in Medication Administration will be ongoing. Consultants will maintain contact lists of Regional Medicaid Offices, Covering Kids pilot offices, and other Medicaid enrollment centers to disseminate to child care centers. Training on Medicaid/LaCHIP will be provided to CCHCs in each Region of the state.

Collaboration with CCHCs, local R & R Agencies, parents, and child care providers, to promote the utilization of CCHCs by child care centers statewide will occur on an ongoing basis. The R&R Agencies will link child care providers with CCHC according to their needs on an ongoing basis. The R&R Agencies will maintain copies of brochures promoting CCHCs and disseminate copies to child care providers and parents on an ongoing basis. The Bureau of Licensing, DSS and Child Care Assistance Program will disseminate brochures in license renewal packet for child care centers and family day homes yearly.

The CCHC Program will maintain a quality assurance system to evaluate the utilization of consultants by child care centers. CCHCs will submit activity reports after each consultation service on an ongoing basis. The Program Director and MCH epidemiologist will review and analyze data from activity reports monthly. The CCHC Program Director and Quality Assurance Committee will audit activities of CCHCs for satisfaction of services on an ongoing basis.

The CCHC Program will continue actively participating with the Early Childhood Comprehensive Systems (ECCS) planning committee and early education and child care workgroup. To increase the number of CCHCs in the northern area of the state a special training conference will be provided for health professionals to become CCHC. Strategies will be developed to include SIDS prevention recommendations in the child care licensing regulations. The CCHC current evaluation component will be revised in a format that will provide reporting requirements and performance measures for the Transitioning Health Child Care America program and administrative data collection requirements.

FIGURE 4B, STATE PERFORMANCE MEASURES FROM THE ANNUAL REPORT YEAR SUMMARY SHEET

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB

1) Percent of all children and adolescents enrolled in public schools in Louisiana that have access to school-based health center services.				
1. SBHCs provide comprehensive preventive and primary physical and mental health services.	☑	☑	☐	☐
2. Set policies and standards for SBHC operation.	☐	☐	☐	☑
3. Provide technical assistance, monitoring, continuous quality improvement in SBHCs.	☑	☐	☐	☑
4. Work to raise level of funding to support SBHC operation.	☐	☐	☐	☑
5. Publish Louisiana School-Based Health Centers Annual Services Report.	☐	☐	☐	☑
6. Collaborate with various entities to promote coordinated school health model.	☐	☐	☐	☑
7. Provide resources to policy makers, educators, service providers, etc. on school health issues.	☐	☐	☐	☑
8. Generate statistical reports on service delivery in Louisiana SBHCs.	☐	☐	☐	☑
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
2) Percent of women in need of family planning services who have received such services.				
1. Provision of family planning services throughout the state in over 90 sites.	☑	☑	☐	☐
2. Identification of potential family planning services contract providers in underserved areas.	☐	☐	☐	☑
3. Provision of community outreach and education to women in need of family planning services.	☐	☑	☑	☐
4. Training of family planning service providers on topics that enhance family planning services.	☐	☐	☑	☑
5.	☐	☐	☐	☐
6.	☐	☐	☐	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
3) The rate of children (per 1,000) under 18 who have been abused or neglected.				
1. Child Health Record psychosocial assessment for children 0-6 in health units.	☑	☐	☐	☐
2. Home visitation services for low-income families.	☐	☑	☐	☐

3. Infant mental health services to low-income families through Healthy Beginnings program.	☐	☑	☐	☐
4. Statewide infant mental health training to public health nurses.	☐	☐	☐	☑
5. Outreach and public education through Prevent Child Abuse Louisiana's media campaign and speakers? bureau.	☐	☐	☑	☐
6. Collection, analysis, and assessment of unexpected child deaths by the Child Death Review Panel.	☐	☐	☐	☑
7. Prevent Child Abuse and Neglect through Dental Awareness (PANDA) training of dental professionals.	☐	☐	☐	☑
8. Public education through new parent's newsletter, Happy and Healthy Kids.	☐	☐	☑	☐
9. Targeted psycho-educational services for at-risk mothers.	☐	☑	☐	☐
10.	☐	☐	☐	☐

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
4) Percent of CSHS patients with case management (follow-up visits) from a nurse, social worker, or nutritionist.				
1. Long Range Plan Needs Assessment to evaluate capacity to provide case management services for CSHCN.	☐	☐	☐	☑
2. Case management services for children attending CSHS clinics.	☐	☑	☐	☐
3. Assessment and linkage to needed services for CSHCN.	☐	☑	☐	☐
4. Medical Home programs promote case management for CSHCN in primary health care settings.	☐	☑	☐	☐
5. Transition services for adolescents aged 14.	☑	☐	☐	☐
6. Facilitate system of follow-up through Medical Home practices.	☐	☐	☐	☑
7. Enhanced Care Coordination Activities.	☐	☐	☐	☑
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
5) Percent of children (2-5) on WIC greater than or equal to the 95th percentile for BMI-for-age.				
1. Counseling and education sessions to families on healthy eating and physical activity.	☐	☑	☐	☐
2. Referrals to WIC Services for specialized one-on-one nutrition counseling.	☐	☑	☐	☐
3. Implementation of the revised BMI-for-age growth charts for children by clinics and health units.	☑	☐	☐	☐
4. Development of educational materials on healthy weight & physical activity for infants and children.	☐	☐	☐	☑
5. Distribution of the Kid?s Activity Pyramid handout to private and public health providers.	☐	☐	☑	☑

6. Training of health providers to enhance their abilities to promote healthy lifestyles with patients.	☐	☐	☐	☑
7. Participation in the Louisiana Obesity Council.	☐	☐	☐	☑
8. Implementation of guidelines for health professionals on healthy weight and physical activities.	☐	☑	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
6) Percent of women who have had a baby who report physical abuse either during their last pregnancy or in the 12 months prior to becoming pregnant.				
1. Implement risk assessment tools in public health clinics to identify domestic abuse.	☐	☑	☐	☐
2. In prenatal clinics, provide referrals to resources for women facing domestic abuse.	☐	☑	☐	☐
3. Provide pre- and post-natal case management for first-time mothers through nurse home visitation services.	☐	☑	☐	☐
4. Distribute domestic violence emergency referral/safety cards to health providers & public.	☐	☐	☑	☑
5. Implement LaPRAMS, which identifies prenatal and postnatal risk factors.	☐	☐	☐	☑
6.	☐	☐	☐	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
7) Percent of women who use substances (alcohol and tobacco) during pregnancy.				
1. Substance abuse treatment and service coordination through the Perinatal Enrichment Program.	☑	☐	☐	☐
2. Home visitation to low-income mothers and infants.	☐	☑	☐	☐
3. Funding for the management of the Louisiana Perinatal Substance Abuse Clearinghouse.	☐	☐	☑	☐
4. Intervention through Make Yours A Fresh Start Family smoking cessation Program.	☐	☑	☐	☐
5. Institution of the Perinatal Risk Assessment Tool.	☑	☑	☐	☐
6. Evaluation of the Maternity Program through Quality Assurance (QA) tools.	☐	☐	☐	☑
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐

9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
8) SPM-11: Rate of infant deaths due to Sudden Infant Death Syndrome.(SPM-08: DISCONTINUED in 2004. Percent of infant deaths due to SIDS that have a complete autopsy and death scene investigation)				
1. Autopsy and death scene investigations are reviewed.	☐	☐	☐	☑
2. SIDS related education programs to health professionals, law enforcement and the public.	☐	☐	☑	☑
3. Distribution of educational materials to hospitals, health providers and daycare centers	☐	☐	☐	☑
4. Discharge teaching tool for hospitals developed from birthing hospital survey data.	☐	☐	☐	☑
5. Collaboration with community-based organizations to disseminate SIDS risk reduction message.	☐	☐	☑	☐
6. Distribution of faith community kits to faith based organizations.	☐	☐	☑	☑
7. Development of a training manual for safe sleep environment promotion for childcare providers.	☐	☐	☐	☑
8. Social marketing campaign about safe sleep environment promotion within high-risk areas.	☐	☐	☑	☐
9. Provision of grief counseling for families of SIDS victims through collaborative agency.	☐	☑	☑	☐
10. Coordination of a SIDS support group in the New Orleans metropolitan area.	☐	☑	☑	☐

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
9) Percent of Central Office and regional epidemiologic positions filled and working on MCH/CSHS data and epidemiologic issues.				
1. Collaboration with regional groups for data requests and analysis.	☐	☐	☐	☑
2. Completion of data reports & requests, epidemiological reports, and program evaluation.	☐	☐	☐	☑
3. Educational activities and support services for regional and local MCH programs.	☐	☐	☐	☑
4. Maintenance of web access to the MCH Data Book and the PRAMS report.	☐	☐	☐	☑
5. Provision of timely epidemiological support at all levels.	☐	☐	☐	☑
6. Assessment of MCH programs and enterprises for epidemiological issues related to MCH.	☐	☐	☐	☑
7. Planning of the statewide conference on perinatal mortality.	☐	☐	☐	☑
8. Maintaining the HRSA-CDC ORISE MCH fellow.	☐	☐	☐	☑
9.	☐	☐	☐	☐
10.				

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
10) Percent of licensed day care centers with a health consultant contact.				
1. Facilitate training opportunities and technical assistance in health and safety in child care.	☐	☐	☐	☑
2. Plan, initiate and coordinate certification training for Child Care Health Consultants.	☐	☐	☐	☑
3. Provide educational materials and training to child care providers on services for CSHCN.	☐	☐	☐	☑
4. Serve as a child care health resource to child care providers and others.	☐	☐	☑	☑
5.	☐	☐	☐	☐
6.	☐	☐	☐	☐
7.	☐	☐	☐	☐
8.	☐	☐	☐	☐
9.	☐	☐	☐	☐
10.	☐	☐	☐	☐

E. OTHER PROGRAM ACTIVITIES

/2005/Infrastructure Building Services

Surveillance
MCH in conjunction with the Genetics and Lead Section in the Office of Public Health has been the recipient of a CDC lead surveillance and prevention grant to establish a statewide population?based childhood lead surveillance system. This Program has begun to utilize data from the surveillance system to develop initiatives in those areas of the State with the highest prevalence of childhood lead poisoning. Initiatives include outreach, public and professional education, and developing partnerships with community agencies and organizations to decrease childhood lead poisoning.

Other information systems to monitor health include development of a statewide immunization registry, ongoing pediatric nutrition surveillance of children and a State Child Death Review Panel, which also coordinates and supports Local Child Death Review Panels.

The CSHS program has implemented recent legislation for a Birth Defects Monitoring Network for surveillance and referral to services. The system has been established with plans to begin surveillance activities in 2004.

Coordination/Policy Development
The MCH Program has participated in the development and implementation of the Early Childhood Supports and Services Program. This 6 Parish pilot Program is an initiative of the Office of Mental that establishes a local system for referral of children from birth to 5 years who are at risk for the development of poor mental health, emotional, or developmental outcomes. Children who are screened and found to be at risk for poor outcomes are referred to a local multi-agency coordinating group who develop a plan to provide the supports and services that are needed to improve the outcomes for the individual children and their families. A system for screening and referral of infants in the pilot parishes through the local public

health units has been implemented.

Through the federally funded State Systems Development Initiative for Early Childhood Comprehensive Services Systems, the MCH Program has worked with the Louisiana Children's Cabinet and its Advisory Group to establish a framework for the implementation of a system of comprehensive services for the early childhood period. The first step in this process has been the completion of a Needs Assessment focusing on the areas of a Medical Home, Mental Health/Socio-emotional Services, Child Care and Early Education, Parent Education, and Family Support Services.

CSHS has provided funding to support the Louisiana Health and Disability Project Surveillance Committee. This committee is composed of professionals and parents representing a wide variety of systems for children with special health care needs: Department of Education, Louisiana Assistive Technology Access Network, Office of Mental Health, Louisiana State University Health Sciences Center, Bureau of Community Supports, Office for Citizens with Developmental Disabilities, The ARC, Family Voices of Louisiana, Part C State Interagency Coordinating Council, Governor's Office of Disability Affairs, Louisiana State Planning Council on Developmental Disabilities, The Children's Cabinet, Head Start, numerous OPH programs, several non-profit disability support groups, as well as parents from the private sector. The purpose of the committee is to develop infrastructure and build capacity to monitor, characterize and improve the health of Louisiana's children with disabilities aged 0 to 5. This committee has successfully reached it goals of: (1) completion of an inventory of state and national data sources/systems relevant to the health and Healthy People 2010 Chapter 6 status of the target population; and (2) compiled a data book summarizing existing information and associated recommendations to address information gaps and data quality concerns. These activities have been used to develop the state plan for health promotion and prevention of secondary conditions for Louisiana's children with disabilities aged birth through 5.

Toll Free Hotline: The Maternal and Child Health Toll-free 1-800 number, entitled Partners for Healthy Babies (1-800-251-BABY), is operated through a contract with D.I.A.L. (Disabilities Information and Access Line) of the Louisiana Department of Health and Hospitals. The phone lines are handled by skilled counselors of D.I.A.L who provide confidential information for women who call seeking referrals for prenatal care and pregnancy testing. Also provided is information regarding primary and preventive services for children, including services for children with special health care needs, as well as referrals for immunizations and information about LaCHIP and Medicaid. The Louisiana OPH Shots for Tots initiative, in coordination with the Partners for Healthy Babies Project, utilizes the helpline number. Family Planning referrals are also available to callers. The helpline provides referrals to the public and private physicians who provide Title V and XIX services. The Partners For Healthy Babies services are communicated to the public through television, radio, billboards and bus placard advertising. In addition, promotional/incentive campaigns, newspaper articles and public relations meetings with community leaders are also utilized to make the public aware of this information and referral service.

Children's Special Health Services has completed the redesign and transfer of the Part C of IDEA system in Louisiana to the Office of Public Health. In addition to the involvement of parents and stakeholders in redesign activities, other offices in OPH as well as DHH continue to be involved in the Part C Program named Early Steps. This includes collaboration with the Early Childhood Comprehensive Systems Services grant.//2005//

F. TECHNICAL ASSISTANCE

Technical Assistance needs are described in Form 15. Please see this form for a complete list of anticipated needs.

V. BUDGET NARRATIVE

A. EXPENDITURES

/2005/MCH Expenditures in fiscal year 2001 compared to 2000 decreased by more than $4.7 million. This was due to an unexpected lay-off of 10 percent of the Office of Public Health workforce at the end of 2000. In addition, contracts were reduced by 10 percent and another 10 percent of the workforce was reduced by attrition. This downsizing of the agency was carried out throughout most programs regardless of the source of funding. These significant events created a wide discrepancy between the MCH budgeted amount and expenditures in fiscal years 2001 and 2002 as illustrated on Forms 3, 4, and 5. The gap was further increased during fiscal year 2002 due to the budgeted amount being based on the amount of the MCH budget request presented to the state legislature. This method was changed and the budgeted amount is determined by an estimate based on recent expenditures and projections.

Successful efforts to redirect funding began soon after the downsizing. A plan was developed based on the 2000 MCH Needs Assessment to establish new infrastructure for MCH activities through contract agencies. Since 2001, MCH staff has been establishing partnerships in each region to build MCH infrastructure and services. The success of these efforts is reflected in the increase in expenditures in fiscal year 2002 compared to 2001. Expenditures are expected to increase to pre-2001 levels in fiscal year 2003 and 2004, and then stabilize in 2005.

FY 2003 Budget figures were obtained from the January 2002 projection which was the latest revenue projection available. By the end of 2002, Medicaid revenue dropped significantly. This drop was due in part to the full implementation of "Community Care" during 2002-2003. Community Care is a Medicaid managed care program. In 2003, Expenditures on Direct Services decreased as did expenditures on Infrastructure Building services. Enabling Services continued to increase. With the institution of Medicaid's Community Care in 2002-2003, clients are moving to private providers for maternal and well child care. Enabling Services increased due to the shift to and expansion of the Nurse Family Partnership home visiting program for pregnant women and children.//2005//

B. BUDGET

/2005/The following services and projects are funded by the MCH Block Grant, Title XIX, patient fees, insurance reimbursements, and local and state funds:
1. Maternity/Family Planning
2. Child Health - Preventive/primary services for children birth to 21.
a. Child Health
b. Communicative Disorders - Preventive
c. Immunization
3. Children's Special Health Services
a. Children's Special Health Services

The MCH Block Grant supports the state central and regional administrative consultative staff who set standards of care, develop policies and procedures, train field staff, and provide quality assurance. The amount budgeted for the Central Office of Public Health MCH staff represents the cost of building the capacity of the state to develop community-based systems of care. This amount is presented for each of the program components. In addition, other core public health services, direct personal health services, enabling services, and population-based services are included in the following budget. Please see the attachment, Tables 1, 2 and 3, for each type of service for each program component, including the amount budgeted for the service separated into the federal and state match contributions.

The service areas (reporting categories), which relate to preventive and primary care services for children, are provided in Table 2 (see attachment). The amount of funds budgeted in these service areas for fiscal year 2005 exceeds 30 percent of the total MCH Block grant. Thus, there

is no need to redirect the MCH program in order to comply with this requirement. Compliance verification based on the actual funds disbursed will be performed and documented by the Fiscal Office at the end of each state fiscal year.

A minimum of 30 percent of federal funds received for use in subsequent fiscal years and the associated match will be budgeted for use in programs that provide services for children with special health care needs. The amounts listed on Table 3 (see attachment) will be budgeted for fiscal year 2005. Compliance verification based on the actual funds disbursed will be performed and documented by the Fiscal Office at the end of each state fiscal year.

Sources of State Match and Overmatch Funds
Funds for Maternal and Child Health Services will be obtained from state general funds.

Program Income
Program income comes from Title XIX funds, fees, and third party payers. Table 4 (see attachment) presents the distribution of this income by program component.

Budgeting for Cross-cutting Programs
The Office of Public Health is able to associate all expenditures including each staff person's work activity with the correct funding source by a system using reporting categories. The Office of Public Health budget is divided into many service areas, each identified by a reporting category. Most Office of Public Health employees utilize this Reporting Category system to allocate their time and other expenditures to a particular project or service area. This system allows staff working across many programs to allocate their time and other expenditures appropriately.

Use of Overmatch Funds
There is no overmatch that is under the control of the State Title V Agency that is used to match other federal programs.

Fees
Maternal and child health patients receiving services at parish health units and are above 100% of the poverty level are charged $5 per clinic visit and $5 for pharmacy services. Individuals receiving only immunizations, and that are above 100% of the poverty level, are charged $10.00. Family planning patients are charged fees according to a sliding fee scale.

Administrative Costs
Administrative costs are the portion of costs incurred by the following service units that are directly allocated to Maternal and Child Health Services Programs in accordance with Sections 3 and 5 (where applicable) of the Department of Health and Hospitals Cost Allocation Plan:
- Office of Assistant Secretary-Management Information Systems (MIS)
- Human Resources Section-Policy, Planning and Evaluation
- Administrative Services-Operations and Support Services
- Statewide Costs (Purchasing, Civil Service, Treasurer, Fiscal, etc.)

Collectively these are referred to as Executive Overhead costs. Compliance verification of the 10 percent administrative restriction will be performed and documented by the Fiscal Office at the end of each state fiscal year. The estimated administrative costs for the total budget are $4,376,520 for fiscal year 2004-2005. The estimated Federal share is $1,429,345 or 10.0% of the federal funds requested.

Administrative Cost Limit - The administrative budget represents 10.0% of the federal funds requested.

"30-30" Minimum Funding Requirements - The preventive and primary care services for children represent 39.8% of the Block Grant and Children's Special Health Services represents

31.9% of the Block Grant budget. The definitions and descriptions of the services for these project components can be found in the program narratives.

Maintenance of State Effort - The State Office of Public Health intends to pursue and expects to obtain state general funds for Maternal and Child Health Services that equals or exceeds the level of such funds provided during state fiscal year 1989. Compliance verification will be performed and documented by the Fiscal Office at the end of each state fiscal year. The state support in state fiscal year 1989 was $6,207,276.

Allocation for Activity Conducted to Continue Consolidated Health Programs
The following federally funded programs were consolidated by the Maternal and Child Health Block Grant in fiscal year 1981 - 1982 in Louisiana:
1. Maternal and Child Health Program;
2. Crippled Children's Services Program (in Louisiana called Children's Special Health Services);
3. Supplemental Security Income/Disabled Children's Program - $298,330 - statewide;
4. Lead-Based Paint Poisoning Prevention Program (previously funded only in City of New Orleans in Louisiana) - $213,032;
5. Genetic Diseases Program (incorporated previous funds for sickle cell disease at Flint Goodridge Hospital in N.O.) $3,407,593;
6. Sudden Infant Death Syndrome (SIDS) - not funded in Louisiana; and
7. Adolescent Pregnancy Program - not funded in Louisiana.

The following state funded programs in effect in Louisiana at the time of Block Grant Legislation in 1981 were also incorporated into the Maternal and Child Health Block Grant:
1. Genetic Diseases Program - statewide screening for certain inherited disorders such as PKU, hypothyroidism, and sickle cell anemia.
2. Sudden Infant Death Syndrome (SIDS) Program - follow-up and counseling of affected families statewide.

Special Projects In Effect Before August 31, 1981
1. Maternal and Infant Care Project - discontinued;
2. Children and Youth Project - discontinued;
3. Family Planning - absorbed into general Family Planning Program; Title V funding for Family Planning Program is $1,750,000;
4. Dental Health For Children - reduced services - current funding for Dental Services for Children's Special Health Services - New Orleans District Office $158,400;
5. Neonatal Intensive Care - absorbed by Louisiana State University Medical Center in Shreveport.//2005//

VI. REPORTING FORMS-GENERAL INFORMATION

Please refer to Forms 2-21, completed by the state as part of its online application.

VII. PERFORMANCE AND OUTCOME MEASURE DETAIL SHEETS

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. GLOSSARY

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. TECHNICAL NOTE

Please refer to Section IX of the Guidance.

X. APPENDICES AND STATE SUPPORTING DOCUMENTS

A. NEEDS ASSESSMENT

Please refer to Section II attachments, if provided.

B. ALL REPORTING FORMS

Please refer to Forms 2-21 completed as part of the online application.

C. ORGANIZATIONAL CHARTS AND ALL OTHER STATE SUPPORTING DOCUMENTS

Please refer to Section III, C "Organizational Structure".

D. ANNUAL REPORT DATA

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.